

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

03967

125L

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 6 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?..... 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D.C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 723 Kennedy St., N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

ADAMS, John George

## 3. (b) Social Security Number

4. Sex..... male  
 5. Color or race..... W-US  
 6.(a) Single, married, widowed, or divorced..... single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... September 16, 1913  
 8. AGE: Years..... 34 Months..... 6 Days..... 19 If less than one day..... hrs. .... min.

9. Birthplace..... Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation..... Post Office  
 11. Industry or business..... U.S. Government  
 12. Name..... ADAMS, Myron H. dec.  
 13. Birthplace..... Wash., D.C.  
 14. Maiden name..... FUREY, Cecil  
 15. Birthplace..... R.I.

16. Informant..... mother: Mrs. Cecil G. Adams  
 Address..... 723 Kennedy St., N.W., Wash., D.C.  
 17. burial Date thereof..... 4-8-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Glenwood  
 Location..... Washington, D.C.  
 18. Funeral director..... HUNTERMAN FUNERAL HOME  
 Address..... 5737 Georgia Avenue, N. W. Wash., D.C.  
 19. 4-5- 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5 April 19 48 at 6:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
29 March 19 48 to 5 April 19 48  
 and that I last saw him alive on 5 April 19 48

Immediate cause of death.....  
Nephrosis (Toxic)  
Uremia  
Hepatitis, Acute

DURATION  
9 days

Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results..... Nephrosis (Toxic, Uremia and Hepatitis)  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... R. L. FLECK, Lt. MC USN  
 M. D. or other  
 Address..... USNH Bethesda, Md. Date signed 4-5-48

RECEIVED

APR 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 03968 414

## 1. PLACE OF DEATH:

County: Montg  
 City or town: Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr.  
 Hospital, institution, or street address where death occurred:  
1110 Flower Ave  
 How long in hospital or institution? 1

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State: MD County: Prince Georges  
 City or town: Landover  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: 8702 - Greenwood Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Walter H Allison

## 3. (b) Social Security Number

4. Sex: M 5. Color or race: W 6.(a) Single, married, widowed, or divorced: Married  
 6.(b) Name of husband or wife: Naomi Trueblood  
 7. Birth date of deceased (mo., day, yr.): March 13, 1914 6.(c) If alive, give age..... years  
 8. AGE: Years: 34 Months: 1 Days: 13 If less than one day..... hrs. .... min.

9. Birthplace: Salvador, Texas  
 (Town, county, and state)

10. Usual occupation: Restaurant Proprietor

11. Industry or business

12. Name: Walter H Allison

13. Birthplace: Texas

14. Maiden name: Catherine Reager

15. Birthplace: Texas

16. Informant: Naomi T Allison

Address: april 29, 1948

17. Burial: Burial Date thereof: april 29, 1948  
 (month) (day) (year)

Cemetery or crematory: Arlington Cemetery

Location: Arlington, Va

18. Funeral director: Th. S. J. Shinn Co

Address: 2901-14th St N.W. Wash, D.C.

19. April 26 19 48 Josephine T. Schaeffer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 19 48, at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 to 19

and that I last saw him alive on Sept. 19

Immediate cause of death: Asphyxia by hanging

(suicide)

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: 4-26-48

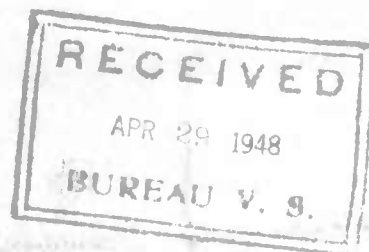
Where did injury occur? Takoma Park, Montg  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) restaurant

Means of injury..... Injured at work?

23. SIGNATURE: Frank J. Bruchart M.D. M. D. or other

Address: Washington Md Date signed: 4-26-48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03969

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bozels (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 weeks  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Bozels (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) if veteran, name war

### 3. (a) FULL NAME

Star Centry

### 3. (b) Social Security Number

NONE

4. Sex fe 5. Color or race white 6.(a) Single, married, widowed, or divorced single  
6.(b) Name of husband or wife  
7. Birth date of deceased (mo., day, yr.) March 6 1948 6.(c) If alive, give age years  
8. AGE: Years 1 Months 21 Days 21 If less than one day hrs. min.

9. Birthplace Washington Co - Md  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Unknown  
13. Birthplace

14. Maiden name Delores Centry  
15. Birthplace Washington Co, Md.

16. Informant T.C. Baker

Address Bozels Md  
17. (Burial, cremation, or removal, Which?) Burial Date thereof 4/28/48  
(month) (day) (year)

Cemetery or crematory Rest Haven  
Location Hagerstown Md

18. Funeral director W. J. Horwath  
Address Hagerstown Md

19. April 27 1948 Abigail G. Cooke  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 27 1948 2:10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1948 to 1948 and that I last saw him alive on Sept 1948

Immediate cause of death Malnutrition DURATION 5 weeks  
Due to Spinal tip 7 weeks  
Due to Paralysis of lower extremities 7 weeks  
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Thos J. Burchard M.D. M. D. or other  
Thos J. Burchard M.D.  
Address Gaithersburg Md Date signed 4-27-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

*Hatman*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 03920  
216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 yr.

Hospital, institution, or street address where death occurred:

4613 Highland Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:-

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4613 Highland Ave.

(If rural, give LOCATION)

2(a) If veteran, name war

No

## 3. (a) FULL NAME.

Mollie Susan Armentrout

## 3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleW.married6. (b) Name of husband or wife Martin Luther Armentrout6. (c) If alive, give age 77 years7. Birth date of deceased (mo., day, yr.) April - 8, 19778. AGE: Years Months Days If less than one day  
71 0 2 hrs. min.9. Birthplace Surry, Page County, Va.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Benzoni Franklin Huffman13. Birthplace Page County, Va.14. Maiden name Eliza Ann Foltz15. Birthplace Page County, Va.16. Informant Husband - Martin L. ArmentroutAddress 4613 Highland Ave., Bethesda, Md.17. Burial April 12, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Washington, D. C.18. Funeral director Wm. Hansen RamseyAddress Bethesda, Maryland19. April 10, 1948  
(Date rec'd by registrar)J. M. E. Johnson  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 April 1948 at 10<sup>00</sup> A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 April 1947 to 10 April 1948 and that I last saw him alive on 8 April 1948

Immediate cause of death

Carcinoma of Liver -  
Pyelonephritis - obstruction of stomach  
Intestines of Cecum -  
in subphrenic space & Pancreas

Due to

Other conditions Diabetes Mellitus mild

(Include pregnancy within 8 months of death)

Major findings of operations Cholelithiasis  
+ cholecystitis Date of op. 20 May 1947Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

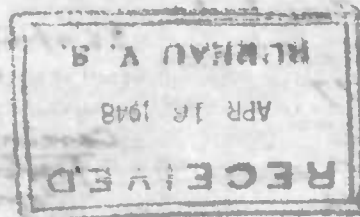
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John S. Ball M.D. M. D. or otherAddress 7936 Kensington Rd. Bethesda, Md. Date signed 10 April 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03971

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

2 days.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Boyd  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Miss Willy Austin

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 8, 1885

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

62925

hrs.

min.

9. Birthplace

Boyd, Montgomery County, Md.  
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

MOTHER FATHER

12. Name

James H. Austin

13. Birthplace

Boyd, Maryland

14. Maiden name

Rhodes Stewart

15. Birthplace

Damascus, Maryland

16. Informant

Hospital record

Address

17.

Burial  
(Burial, cremation, or removal, Which?)

Date thereof

4/8/48  
(month) (day) (year)

Cemetery or crematory

St Mary Cemetery

Location

Barnesville Md.

18. Funeral director

P. P. Carter

Address

Fairbairn Md.

19.

April 7  
(date rec'd by registrar)

19.

48 Almeda L. Cooke

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1948 at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 3 1948 to April 5 1948and that I last saw her alive on April 5 1948Immediate cause of death Cerebral Hemorrhage

DURATION

12 hrs

Due to

Thrombosis Interstitial  
nephritis & Hypertension

Due to

Other conditions

Filariasis of uterus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Sandy Spring

M. D. or other

Address Sandy Spring, Md. Date signed 4/5/48

RECEIVED

APR 9 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Washington SanitariumHow long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town 10802 St Paul St  
(If outside city or town limits, write RURAL and give nearest town)Street No. Kensington  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

SUSAN E BAKER

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife HARRY WILLIAM BAKER6. (c) If alive, give age 36 years7. Birth date of deceased (mo., day, yr.) DECEMBER 20, 1912

## 8. AGE:

Years

Months

Days

If less than one day

35322

hrs.

min.

9. Birthplace Rock Creek, North Carolina  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

## FATHER

12. Name Robert Malthus Barefoot13. Birthplace Wilson County North Carolina

## MOTHER

14. Maiden name ANNA Bayette15. Birthplace Wilson County, North Carolina16. Informant MR. HARRY W. BAKERAddress 10802 ST. PAUL ST. KENSINGTON, MD.

## 17. Burial

(Burial, cremation, or removal, Which?)

Date thereof April 15, 1948

(month) (day) (year)

Cemetery or crematory Contentie Church CemeteryLocation Wilson County, N. C.18. Funeral director Warner E. PumpheyAddress 8434 Ga. Ave. Silver Spring, Md.

## 19. April 13 1948

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/48 1948 at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/11/48 1948 to 4/12/48 1948and that I last saw him alive on 4/12/48 1948

Immediate cause of death

DURATION

Pneumonia Virus B. & D.Due to Bronchiectasis2 weeksDue to EmphysemaDue to Chronic AsthmaOther conditions Bronchiectasis, Emphysemaand lobular pneumonia at P.M.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results See above plus virus pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Kensington, Md. Date signed 4/12/48

MARGIN RESERVED FOR BINDING

VS A15 9-25-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
APR 16 1948  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

216

1. PLACE OF DEATH: Montgomery  
 County Bethesda (rural)  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 months, 2 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 4 months, 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C. County Sp. Am.  
 City or town 1343 Clifton Street, Apt. 26  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. (If rural, give LOCATION)  
 2.(a) If veteran, name war Sp. Am. ✓

## 3.(a) FULL NAME

BANKERT, Silas Milton

## 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married  
 8.(b) Name of husband or wife Alice G. Bankert  
 8.(c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) June 6, 1869  
 8. AGE: Years 78 Months 9 Days 26 It less than one day hrs. min.

9. Birthplace Penn. (Town, county, and state)  
 10. Usual occupation Retired Marine Corps  
 11. Industry or business  
 12. Name BANKERT, Robert F. Dec.  
 13. Birthplace Pa.  
 14. Maiden name KIRBY, Nelly dec.  
 15. Birthplace Ireland

16. Informant son: Mr. P. E. Bankert  
 Address 1343 Clifton Street, Apt. 26, Wash., D.C.  
 17. burial Date thereof 4-7-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Virginia  
 18. Funeral director S. H. HINES  
 Address 2901 14th St. N.W. Washington, D. C.  
 18. 4-3- 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

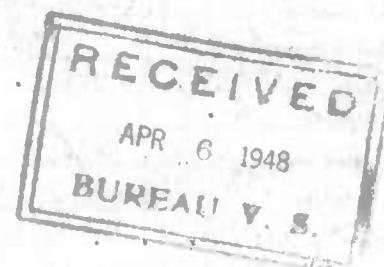
20. DATE OF DEATH 2 April 19 48 et 6:20 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 November 19 47, to 2 April 19 48, and that I last saw him alive on 2 April 19 48  
 Immediate cause of death Lobar Pneumonia  
Rt. lower lobe  
 DURATION 3 days  
 Due to Carcinoma Stomach 6 Mos  
 Due to  
 Other conditions old Fibrous Pleurisy 7 years  
and pericarditis  
 (include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results Same as above.  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Manner of injury Hb. Messerschmidt Injured at work  
H. C. MESSERSCHMIDT,  
 23. SIGNATURE H. C. MESSERSCHMIDT, M. D. 4-3-48  
 Address USNH Bethesda, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

03973

466-X



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03974

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 years  
 Hospital, institution, or street address where death occurred:  
120 - South Adams St  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 120 - South Adams Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Laura E.

## 3. (b) Social Security Number

Barnsley

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Widowed

## 5. (b) Name of husband or wife

Samuel H. Barnsley

## 7. Birth date of deceased (mo., day, yr.)

September 28 - 1852

## 6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

95616

hrs.

min.

## 9. Birthplace

New Market - Frederick Co - Maryland  
(Town, county, and state)

## 10. Usual occupation

House wife

## 11. Industry or business

MOTHER FATHER

## 12. Name

John Umstead

## 13. Birthplace

Maryland

## 14. Maiden name

Emily Hyatts

## 15. Birthplace

Maryland

## 16. Informant

Miss Effie Barnsley - Daughter

## Address

120 - South Adams - Rockville Md

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

Apr. 16/48  
(month) (day) (year)

## Cemetery or crematory

St. John's Episcopal Ch - Cmt

## Location

Shury - Mount. Co - Maryland

## 18. Funeral director

Wm. Reuben Humphrey

## Address

Rockville - Maryland

## 19.

4/15  
(Date rec'd by registrar)1948W. H. Thompson  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

4/14/1948 at 12 M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/1/1946to 4/14/1948

and that I last saw him alive on

3/27/1948

## Immediate cause of death

Coronary thrombosis

## DURATION

## Due to

General atherosclerosis

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

\*Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

## 23. SIGNATURE

W. H. Thompson

M. D. or other

## Address

Rockville, MdDate signed 4/15/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03975

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 Years

Hospital, institution, or street address where death occurred:

Home - 119 East Bradley Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 119 East Bradley Lane  
(If rural, give LOCATION)2.(a) If veteran, name war World War I (Navy)

## 3. (a) FULL NAME

EVELYN KERR BAUMANN

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced6.(b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) October 4, 18988. AGE: Years 49 Months 49 Days 6 If less than one day 21 hrs. min.9. Birthplace Washington, D. C.  
(Town, county, and state)10. Usual occupation Clerk - Veterans Administration

## 11. Industry or business

12. Name James K. Kerr13. Birthplace Washington, D. C.14. Maiden name Susanna Davis15. Birthplace Washington, D. C.16. Informant Susanna Davis KerrAddress 1410 M St., N.W., Washington, D.C.17. Burial Date thereof April 29, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill CemeteryLocation Prince George County18. Funeral director The S. H. Himes Co.Address 2901 14th St., N.W., Washington, D.C.19. 4/28 19 48 Wm E. Jones

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1948 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. med. Sec. care 19 19  
and that I last saw him alive on 19

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Byers M.D.Address Washington, D.C. Date signed 4-26-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 29 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

03976

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 days  
Hospital institution or place address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution? 3 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Washington, D. C. County \_\_\_\_\_  
City or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2447 M St., N.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war WWII

### 3. (a) FULL NAME

BEASLEY, Ernest Reginald

### 3. (b) Social Security Number

4. Sex Male 5. Color or race N-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) June 14, 1906 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 41 Months 10 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business \_\_\_\_\_

FATHER 12. Name BEASLEY, David dec.  
13. Birthplace Mass.

MOTHER 14. Maiden name FERGUSON, Fannie  
15. Birthplace Va.

16. Informant mother: Mrs. Fannie Beasley  
Address 2447 M St., N. W., Wash., D.C.

17. burial Date thereof 4-29-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Arlington National  
Arlington, Virginia  
Location \_\_\_\_\_

18. Funeral director BOYD Funeral Home AB  
Address 123820th St., N.W., Wash., D.C.

19. APR 27 1948 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH APR 27 1948 at 6:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APR 23 1948 to APR 27 1948  
and that I last saw him in alive on APR 27 1948

Immediate cause of death Hypertensive Heart Disease DURATION indef.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Congestive Heart Failure indef.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accidental, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

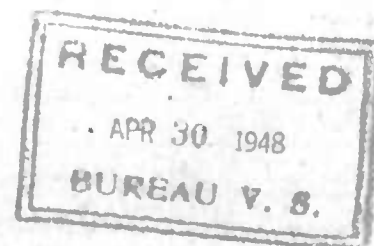
23. SIGNATURE L. E. Watters  
L. E. WATTERS, Jr., Lt JG MC USN  
M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. APR 27 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 03977  
273

## 1. PLACE OF DEATH:

County MontgomeryCity or town Darnestown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Home - Dranestown, Maryland

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Darnestown  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war No

## 3. (a) FULL NAME

MYRTLE BELLE

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Elijah Howard Bolton6. (c) If alive, give age 63 years

## 7. Birth date of

deceased (mo., day, yr.)

April 13, 1890

## 8. AGE:

Years

Months

Days

It less than one day

57571129

hrs.

min.

## 9. Birthplace

Quince Orchard, Maryland

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

Andrew J. Mobley

## 13. Birthplace

Frederick Co., Maryland

## MOTHER

## 14. Maiden name

Hattie M. Selby

## 15. Birthplace

Montgomery Co., Maryland

## 16. Informant

Elijah Howard Bolton

## Address

Darnestown, Maryland

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 15, 1948  
(month) (day) (year)

## Cemetery or crematory

Forest Oak, Gaithersburg, Md.

## Location

Gaithersburg, Maryland

## 18. Funeral director

## Address

Bethesda 14, Maryland

## 19. April 15 19 48

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th 1948 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 9 1948 to Apr. 12 1948and that I last saw him alive on Apr. 12 1948

Immediate cause of death

Carcinoma of intestinal tract

DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

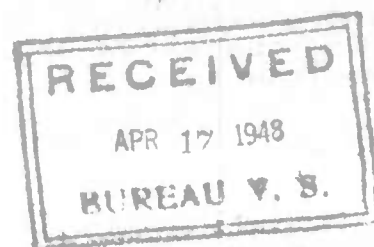
Injured at work?

23. SIGNATURE

J. J. Bruchart M.D.

M. D. or other

Address Gaithersburg md Date signed 4/13/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 13472 03978 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution? 2 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5621 Greentree Rd.  
 (If rural, give LOCATION)  
 2.(a) Is veteran, name war No

## 3. (a) FULL NAME

Mrs. Jane R. Bradley

## 3. (b) Social Security Number

None

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Female white widow

## 6. (b) Name of husband or wife

J. Herbert

## 7. Birth date of deceased (mo., day, yr.)

July 28, 1878

## 6. (c) If alive, give age

Dec. years

## 8. AGE:

Years

Months

Days

If less than one day

69 69 8 9 hrs. min.

## 9. Birthplace

West Alexander, Pa.  
(Town, county, and state)

## 10. Usual occupation

House wife

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

John B. Reed

## 13. Birthplace

West Alexander, Pa.

## 14. Maiden name

Mary S. Stone

## 15. Birthplace

Greene Co. Pa.

## 16. Informant

J. Reed Bradley (son)

## Address

same

## 17. Burial - Transit

April 7, 1948  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

## Cemetery or crematory

West Alexandria Cemetery

## Location

West Alexandria, Pennsylvania

## 18. Funeral director

Wm. Lauren Rumphrey

## Address

Bethesda, Maryland

## 19. (Date rec'd by registrar)

4/7/48

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 6, 1948 at 10:15 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on April 1948 to April 1948

## and that I last saw him alive on

Immediate cause of death Cerebral hemorrhage

## DURATION

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

## Where did injury occur?

(City or town)

(County)

(State)

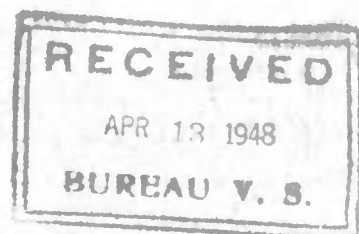
## Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

Charles R. R. Halley M.D.  
985-19th St N.W. Date signed April 1948



MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 838 03679 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Westgate  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Westgate  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 203 Newport Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

GEORGE LEWIN BUNNELL

## 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Anne Ryan Bunnell  
 6.(c) If alive, give age 57 years  
 7. Birth date of deceased (mo., day, yr.) August 8, 1882  
 8. AGE: Years 65 Months 8 Days 20 If less than one day hrs. min.

9. Birthplace Upper Marlboro, Maryland  
 (Town, county, and state)  
 10. Usual occupation Real Estate  
 11. Industry or business

FATHER 12. Name George Henry Bunnell  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Louisa Coale  
 15. Birthplace Falmouth, England

16. Informant Mrs. Anne Ryan Bunnell  
 Address 203 Newport Avenue Westgate, Md.

17. Burial Date thereof May 1, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mount Olivet Cemetery  
 Location Washington, D.C.

18. Funeral director James B. Ryan, Inc.  
 Address 317 Pennsylvania Avenue, S.E.

19. 4/29 1948 H. E. Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1948 at 2:45 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1948 to April 25, 1948  
 and that I last saw him alive on April 25, 1948  
 Immediate cause of death Cerebral thrombosis  
 Due to Arteriosclerosis  
 Due to  
 Other conditions  
 (Include pregnancy within 8 months of death)

## DURATION

15 yrs.  
6 years

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE B. T. Benjamin, M.D.  
 M. D. or other  
 Address Bethesda, Md. Date signed 4/29/48

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAY 5 1948

BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

03980

## 1. PLACE OF DEATH

County Montgomery Registration Dist. No. 211  
 Village or City Hyattstown No. 1310 St. 211 Ward 211  
 Length of residence in city or town where death occurred 86 yrs. 8 mos. 1 ds. (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 How long in U.S. if of foreign birth? yrs. mos. ds.

## 2. FULL NAME

Webster Voorhees Burdette  
 (a) Residence: No. 1310 St. 211 Ward 211  
 (Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Mary E. Burdette</u>		
6. DATE OF BIRTH (month, day, and year) <u>8-28-1861</u>		
7. AGE Years <u>86</u> Months <u>8</u> Days <u>1</u>	If LESS than 1 day, _____ hrs. of _____ min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Carpenter</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.	
	10. Date deceased last worked at this occupation (month and year) <u>1938</u>	
	11. Total time (years) spent in this occupation	

FATHER	12. BIRTHPLACE (city or town) (State or country) <u>Clarksburg, Md.</u>
	13. NAME <u>John E. Burdette</u>
MOTHER	14. BIRTHPLACE (city or town) (State or country) <u>Montgomery</u>
	15. MAIDEN NAME <u>Mary E. O'Kathen</u>
	16. BIRTHPLACE (city or town) (State or country) <u>Montgomery, Md.</u>
	17. INFORMANT <u>L. M. Stone</u> (Address) <u>Hyattstown, Md.</u>
	18. BURIAL, CREMATION, OR REMOVAL Place <u>Hyattstown, Md.</u> Date <u>5-1</u> , 19 <u>48</u>
	19. UNDERTAKER <u>M. P. O'Kathen &amp; Son</u> (Address) <u>Hyattstown, Md.</u>
	20. FILED <u>April 25, 1948</u> <u>Wella M. Burdette</u> Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April 29, 1948  
 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from May 10, 1946, to April 29, 1948  
 I last saw him alive on April 29, 1948; death is said to have occurred on the date stated above, at 10:35 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Uremia

Other Contributory Causes of Importance: Chronic Interstitial Nephritis, 1946  
Arterio Sclerosis, 1938

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (Specify city or town, county and State)  
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify  
 (Signed) Ernest P. Roop M. D.  
 (Address) New Market, Md.



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

159

03381

Reg. Dist. No. 216

**PLACE OF DEATH:**  
 County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Birth  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital, Old geo. Rd.  
 How long in hospital or institution? Birth

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Kensington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 11- Lincoln Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Celeste

Byham

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) April, 28, 1948 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If less than one day 15 hrs. 13 min.

8. Birthplace Bethesda, Montgomery, MARYLAND  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Carl Lester Byham  
 13. Birthplace Kane Penn.

14. Maiden name Carol Celeste Kennedy  
 15. Birthplace Pulaski, Tenn.

16. Informant CARL Lester Byham  
 Address 11- Lincoln Ave, Kensington, Md.

17. Burial Date thereof \_\_\_\_\_ (month) (day) (year)  
 (Burial, cremation, or removal. Which?)  
 Cemetery or crematory Rock Creek Cem  
 Location Washington, D.C.

18. Funeral director Joseph Smolin's Sons  
 Address 1756 Penn Ave, NW

19. 4/30 19 48 Mr E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 19 48 at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/28 19 48 to 4/30/48 19  
 and that I last saw him alive on 4/30/48 19

Immediate cause of death Pneumonia  
Respiratory Distress

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

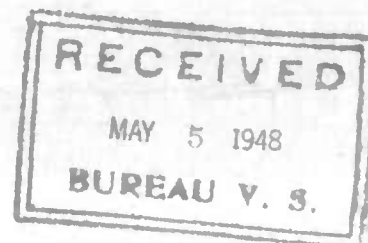
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Lester Byham M. D. or otherAddress Bethesda MD Date signed 4/30/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03982

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 25 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Cuba County \_\_\_\_\_  
 City or town Camaguey  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

CADENAS, Felipe Enrique Aguilera

## 3. (b) Social Security Number

4. Sex male 5. Color or race Cuban 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Flora Cadenas  
 7. Birth date of deceased (mo., day, yr.) February 6, 1895 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 53 Months 2 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cuba  
 (Town, county, and state)  
 10. Usual occupation Cuban Navy  
 11. Industry or business \_\_\_\_\_  
 12. Name CADENAS, Jose dec.  
 13. Birthplace Cuba  
 14. Maiden name Aguilera, Mariana dec.  
 15. Birthplace Cuba

16. Informant Mrs. Flora Fernandez de Cadenas  
 Address Shoreham Hotel, Washington, D.C.  
 17. burial removal Date thereof Apr. 16, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Colon Cemetery  
 Location Havana, Cuba  
 18. Funeral director S. H. HINES C. L. S.  
 Address 2901 14th St., N. W., Wash. D.C.  
 19. 4-14 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 14 April 19 48 at 2:40 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 March 19 48 to 14 April 19 48  
 and that I last saw him alive on 14 April 19 48

Immediate cause of death Coronary Artery Thrombosis DURATION 1 hr.  
 Due to Coronary Heart Disease over 25 da.  
Arteriosclerotic  
 Due to \_\_\_\_\_  
 Other conditions Valvular Heart Disease indef.  
Mitral Insufficiency  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results not performed  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE T. E. JARRETT Cdr. MC USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 4-14-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

03983

223-

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MONTGOMERYCity or town Pactville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 4  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Carey, Mr. Phillip Lawrence

## 3. (b) Social Security Number

523-05-1141

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Carey, Mrs. Anna

7. Birth date of deceased (mo., day, yr.)

Oct. 15, 1873

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

74529

hrs.

min.

9. Birthplace New Brunswick, Quebec, Canada  
(Town, county, and state)10. Usual occupation Business Man11. Industry or business Business Controls Service

FATHER

12. Name

Abraham Carey

13. Birthplace

Quebec, Canada

MOTHER

14. Maiden name

Ellen Nellis

15. Birthplace

Quebec, Canada16. Informant Wash. San. & Hosp. Records

Address

Takoma Park, Maryland

17.

Burial

Date thereof

April 17, 48

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Holy Cross

Location

Malden, Middlesex Co. Mass.

18. Funeral director

Warner E. Humphrey

Address

8434 Ga. Ave., Silver Spring, Md.

19.

April-15-48

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 13 1948 at 11:50am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 9 1948 to Apr 13 1948  
and that I last saw him alive on Apr 12 1948

Immediate cause of death

nephritis

DURATION

10 months?

Due to

Due to

Other conditions

Hepatitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John N. Andrews M.D.  
9601 Colesville Rd  
Silver Spring, Md

M. D. or other

Address

Date signed 4-13-48

**RECEIVED**

APR 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

103984

216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution? 20 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.F.D. #1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Thomas Carroll  
 4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Jarah  
 7. Birth date of deceased (mo., day, yr.) Jan. 2, 1867  
 6.(c) If alive, give age years

8. AGE: Years 81 Months 3 Days 5 If less than one day hrs. min.

9. Birthplace Washington D.C.  
 (Town, county, and state)

10. Usual occupation Retired

## 11. Industry or business

12. Name Joseph Carroll  
 13. Birthplace Washington, D.C.  
 14. Maiden name Catherine Rabbitt  
 15. Birthplace Washington, D.C.

16. Informant wife  
 Address same

17. Burial Date thereof April 10, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rockville Union  
 Location Rockville, Maryland

18. Funeral director Warner C. Pumphrey  
 Address 8434 Georgia ave., Silver Spring, Md.

19. 4/15/48 Registrar Wm E. Jones  
 (Date rec'd by registrar)

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1948 at 8:22 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from (2:05 am) 4-7-48 to 4-7-48  
 and that I last saw him alive on 4-7-48  
 Immediate cause of death coronary occlusion DURATION

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm B. Ford, M.D.  
 M. D. or other

Address Suburban Hospital Date signed 4-7-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
birth date shown on:

FILM No. G 115 APR 23 1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03985  
Reg. Dist. No. 213

### 1. PLACE OF DEATH:

County Montgomery  
City or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 22 yrs.  
Hospital, institution, or street address where death occurred:  
910 Grandin Avenue  
How long in hospital or institution? None

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 910 Grandin Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

### 3. (a) FULL NAME

EDITH MAE CHAPMAN

### 3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Marion Lee Chapman</u>		
7. Birth date of deceased (mo., day, yr.) <u>November 10, 1884/1883</u>		
8. AGE: Years Months Days If less than one day		
<u>65</u>	<u>65</u>	<u>6</u>
<u>4</u> hrs. <u>4</u> min.		

9. Birthplace Ohio  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business None

FATHER  
12. Name John H. Hubbard  
13. Birthplace Pennsylvania

MOTHER  
14. Maiden name Margaret Lee  
15. Birthplace Unknown

16. Informant Mr. Marion L. Chapman  
Address Rockville, Maryland

17. Burial Apr. 17, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Forest Oak Cemetery  
Location Gaithersburg, Maryland

18. Funeral director W. Reuben Thompson  
Address Bethesda, Maryland

19. 4/16/48 19 SV Thompson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 14 19 48 at 8:45 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
APRIL 13 19 48 to APRIL 14 19 48  
and that I last saw her alive on APRIL 14 19 48

Immediate cause of death  
MASSIVE CEREBRAL  
HEMORRHAGE  
Due to HYPERTENSIVE  
HEART DISEASE

#### DURATION

1 HR.

10-15/RS.

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
Accident, suicide, or homicide None Date of None  
Where did injury occur? None (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) None  
Means of injury None Injured at work? None

23. SIGNATURE Garson S. Rosenberg, M.D.  
Address Rockville, Maryland Date signed 4/15/48

**RECEIVED**

APR 17 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

## CERTIFICATE OF DEATH

03986

216

Reg. Dist. No. ....

1. PLACE OF DEATH: Montgomery  
 County.....  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Virginia County..... Arlington  
 City or town..... Arlington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4225 Lorcom Lane  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

CLEXTON, Zita Langhorne

## 3. (b) Social Security Number

4. Sex..... female  
 5. Color or race..... W-US  
 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Edward W. Clexton  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... October 18, 1898  
 8. AGE: Years..... 49 Months..... 6 Days..... 12  
 If less than one day..... hrs. .... min.

9. Birthplace..... California  
 (Town, county, and state)  
 10. Usual occupation..... housewife  
 11. Industry or business.....  
 FATHER  
 12. Name..... SP LANGHORNE, John D.  
 13. Birthplace..... N.J.  
 MOTHER  
 14. Maiden name..... SPENCER, Zita  
 15. Birthplace..... England

16. Informant..... husband: Capt. Edward W. Clexton USN  
 Address..... 4225 Lorcom Lane Arlington Virginia  
 17. burial Date thereof..... 5-1-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National  
 Location..... Arlington Virginia  
 18. Funeral director..... Fitzgerald Funeral Home W.E.F.  
 Address..... 3245 Wilson Blvd. Arlington, Va.  
 19. 5-1-48 xx Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 30 April 19 48 at 11:55P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
18 April 19 48 to 30 April 19 48  
 and that I last saw h..... or alive on 30 April 19 48

Immediate cause of death..... Cachexia, extreme  
 Due to..... Recurrent Adeno Carcinoma  
Stomach  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

## DURATION

3 mo.

Major findings of operations.....  
 Date of op.....  
 Autopsy results..... Adeno Carcinoma, Stomach  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?  
 23. SIGNATURE..... J. T. FOWLER, Jr. MC USN  
M. D. or other  
 Address..... USNH Bethesda, Md. Date signed..... 5-1-48

RECEIVED

MAY 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03987

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8014 Custer Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County MONTGOMERY Co.City or town BETHESDA  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8014 CUSTER ROAD  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ANITA COLE

## 3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife SAMUEL F. COLE

6. (c) If alive, give age. years

7. Birth date of

deceased (mo., day, yr.)

JUNE 21, 1880

8. AGE:

Years

Months

Days

If less than one day

67926

hrs.

min.

9. Birthplace

WASHINGTON, D.C.  
(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

FATHER

12. Name HENRY L. TAYLOR13. Birthplace FORESTVILLE, MD.

MOTHER

14. Maiden name ANNIE BERRY15. Birthplace PRINCE GEORGES Co., MD.16. Informant SAMUEL F. COLEAddress 8014 CUSTER RD, BETHESDA, MD.17. Burial  
(Burial, cremation, or removal. Which?)Date thereof ap. 19, 1948  
(month) (day) (year)Cemetery or crematory Woodlawn Cemetery

Location

18. Funeral director The S. H. Hines CoAddress 2901 14TH ST. NW19. april 18 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948, at 4:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1944, to April 17 1948and that I last saw her alive on April 15 1948

Immediate cause of death

Generalized Arteriosclerosis

DURATION

10 years

Due to

Due to

Other conditions

Melanosis2 months

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bruce Benjamin MD.

M. D. or other

Address Bethesda, Md. Date signed 4/21/48

RECEIVED

APR 21 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03988

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (RURAL)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 1/2 hours 4 min.  
Hospital, institution, or street address where death occurred:  
Suburban Hospital, Georgetown Rd.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R.R. # 3  
(If rural, give LOCATION)  
2. (a) If veteran, name war No

### 3. (a) FULL NAME

Robert Eugene Combs

### 3. (b) Social Security Number

NONE

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced infant

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) April 12, 1948 8. (c) If alive, give age 4 years

8. AGE: Years 1 Months 1 Days 4 hrs. 4 min.

9. Birthplace Gaithersburg, Md. (home)  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Lloyd Lincoln Combs

13. Birthplace Chesapeake, W. Va.

14. Maiden name Hattie Irene Battiff

15. Birthplace Gaithersburg, Md.

16. Informant Suburban Hospital, Georgetown Rd.

Address Bethesda, Md.

17. Burial Date thereof April 15, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery

Location Gaithersburg, Maryland

18. Funeral director William Ruten Pughley

Address Bethesda 14, Maryland

19. April 15 19 48 Mr. E. Jones

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 48 at 4:04 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/13/48 to 4/13/48 and that I last saw him alive on 4/13/48

Immediate cause of death Atoketown

Due to Pneumonia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Jones

Address 2710 Linn. Ave.

Date signed 4/15/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 24 1948

BUREAU F. B. I.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03989

## CERTIFICATE OF DEATH

Reg. Dist. No. 222

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 yr. 7 mo. 15 da.  
Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
How long in hospital or institution? 1 yr. 7 mo. 15 da.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 707 Carroll Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Cornor, Mrs. Sarah Cassell

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
6.(b) Name of husband or wife George Cornor  
7. Birth date of deceased (mo., day, yr.) Oct. 6, 1860  
6.(c) If alive, give age..... years  
8. AGE: Years 87 Months 6 Days ..... hrs. .... min.

9. Birthplace Salem, Ohio  
(Town, county, and state)  
10. Usual occupation House wife  
11. Industry or business Own home  
12. Name WILLIAM CASSELL  
13. Birthplace BALTIMORE, Md.  
14. Maiden name LUCINDA COFFMAN  
15. Birthplace PENNA.

16. Informant Wash. San. & Hosp. Records  
Address Takoma Park, Maryland  
17. Burial Date thereof April 8, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory GEO. WASH. MEMORIAL CEMETERY  
Location Riggs Rd., Hyattsville, Md.  
18. Funeral director J. ARTHUR WALTERS  
Address 254 CARROLL ST. N.W., TAKOMA PARK, D.C.  
19. April 7, 48  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1948 at 7:55 a.m.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 46 to April 6, 1948  
and that I last saw him alive on 4-6-1948  
Immediate cause of death Congestive Cardiac Failure  
Due to Cerebral Hemorrhage 3 days  
Due to Atherosclerosis years  
Other conditions .....  
(Include pregnancy within 8 months of death)

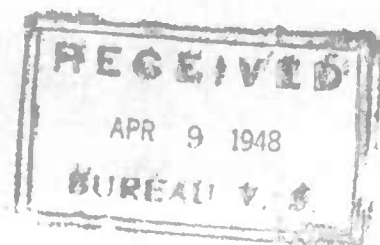
Major findings of operations..... Date of op. ....  
Autopsy results X  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Robert A. Hare MD.  
Address Takoma Park, Md. Date signed 4/6/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03990

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 months, 12 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 4 months, 12 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Mo. County           
City or town Kansas City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 850 West 53rd Terrace  
(If rural, give LOCATION)  
2. (a) If veteran, name war WWI

### 3. (a) FULL NAME

COULTER, Virgule Milton

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Leah L. Coulter

7. Birth date of deceased (mo., day, yr.) July 12, 1892 8. (c) If alive, give age          years

8. AGE: Years 55 Months 8 Days 20 If less than one day          hrs.          min.

9. Birthplace Ark.  
(Town, county, and state)

10. Usual occupation Retired Navy

11. Industry or business         

12. Name COULTER, Marion C. dec.

13. Birthplace Ark.

14. Maiden name POWELL, Harriet M.

15. Birthplace Ark.

16. Informant wife: Mrs. Leah L. Coulter

Address 850 West 53rd Terrace, Kansas City, Mo.

17. Burial Removal Date thereof Apr 3, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Masonic Cemetery

Location Kansas City, Mo.

18. Funeral director W. W. Chambers R.P.

Address 1400 Chapin St. N.W., Washington, D.C.

19. 4-2- 18 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2 April 19 48 at 12:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 November 19 47 to 2 April 19 48

and that I last saw him alive on 4-2- 19 48

Immediate cause of death Kidneys disease DURATION         

Due to         

Due to         

Other conditions         

(Include pregnancy within 3 months of death)

Major findings of operations         

Date of op.         

Autopsy results         

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide          Date of         

Where did injury occur?          (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)         

Means of injury          Injured at work?         

23. SIGNATURE Wm P Norton M.C.P.  
M.D. or other         

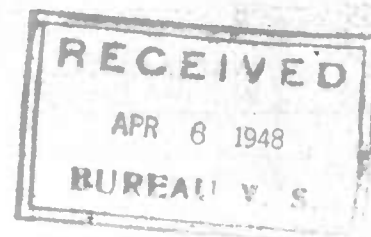
Address U.S. Naval Hosp Bethesda 4-2-48  
Date signed         

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03991

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
City or town Norbeck  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Norbeck  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George E. Dorsey Jr.

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Elvira Henry

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

Feb 16, 1891

8. AGE:

Years

Months

Days

If less than one day

57

hrs.

min.

9. Birthplace

Norbeck, Mont. Md.  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 48

Gertrude B. Lawler

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 29, 1948 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 18, 1940 to April 29, 1948and that I last saw him alive on April 29, 1948

Immediate cause of death

DURATION

Coronary Embolism 1 hour

Due to

Coronary Sclerosis

Due to

Myocarditis &

Other conditions

HypertrophyHypertension  
(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

W. H. Sewell, M.D.  
Norbeck, Md. Date signed May 1, 48

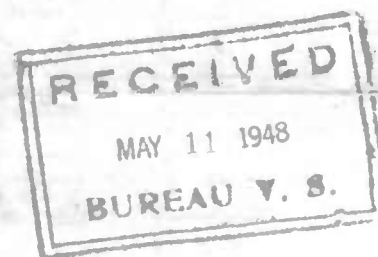
MARGIN RESERVED FOR BINDING

1

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAY 11 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 03992 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 3/4 hrs  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium  
 How long in hospital or institution? 6 3/4 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Silver Springs  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9512 Garwood St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Reuben Roszel Duffie

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mary C. Duffie  
 7. Birth date of deceased (mo., day, yr.) Sept. 20, 1887 6.(c) If alive, give age..... years  
 8. AGE: Years 60 Months 6 Days 21 If less than one day..... hrs. .... min.

9. Birthplace Washington D.C.  
 (Town, county, and state)  
 10. Usual occupation Retired U.S. Govt. worker  
 11. Industry or business.....

FATHER 12. Name John Duffie  
 13. Birthplace S. Carolina  
 MOTHER 14. Maiden name Florence Sullivan  
 15. Birthplace Georgetown D.C.  
 16. Informant Sanitarium Records

Address.....  
 17. Burial Date thereof April 14, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Int. Olivet  
 Location Washington D.C.  
 18. Funeral director Warner E. Pumphrey  
 Address Silver Spring Md.

19. April 12, 1948 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 11 1948 at 8:30 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 11 1948 to Apr 11 1948  
 and that I last saw him alive on Apr 11 1948

Immediate cause of death Left Cerebral Hemorrhage  
Hypertension  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....  
 Autopsy results Left Cerebral Hemorrhage  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

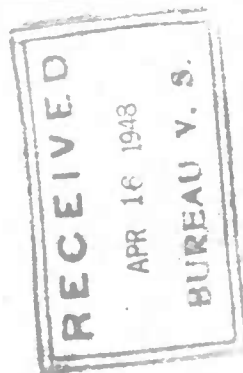
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Reuben S. Harding MD  
113 Camel St NW  
 Address Washington DC Date signed 4-11-48

Montgomery County Coroner notified  
by telephone of this case and he  
approves certificate. We hold a  
post-mortem permit signed by son  
of deceased so are going ahead with  
autopsy

4-11-48

Dean Harding MS  
113 Carroll St NW  
Wash DC



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03993

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

of 8710 Conn. avHow long in hospital or institution? Dead on arrival

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 Jones Bridge Rd.  
(If rural, give LOCATION)2.(a) If veteran, name war World War I

## 3. (a) FULL NAME

Walter Clayton Duke

## 3. (b) Social Security Number

146169

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Minnie

## 7. Birth date of

deceased (mo., day, yr.) Oct. 16, 1888.6. (c) If alive, give age 45 years

## 8. AGE:

Years 69 Months 5 Days  If less than one day  
hrs. min.

## 9. Birthplace

Pittsburgh, Pa.  
(Town, county, and state)

## 10. Usual occupation

Painter & decorator

## 11. Industry or business

Charles Duke

## FATHER

12. Name Charles Duke13. Birthplace Charlottesville, Va.14. Maiden name Mary Mc Casin15. Birthplace Pittsburgh, Pa.16. Informant wifeAddress same17. Burial Date thereof April 14, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington National CemeteryLocation Arlington, Virginia18. Funeral director Wm. Hudson HumphreyAddress Bethesda, Maryland19. 4/12 19 48 Wm E Johnson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1948 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med Exam caseand that I last saw h. alive on  19 Immediate cause of death Human errordue to crushed chest(accidental)Due to Due to Other conditions 

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

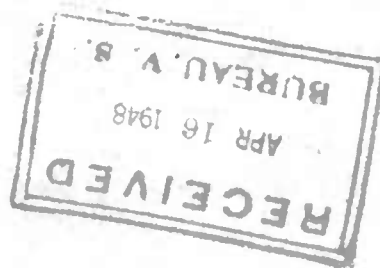
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4/11/48Where did injury occur? Cherry Chase Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) factoryMeans of injury Struck by auto Injured at work? noSignature Frank J. Brochert M.D.23. SIGNATURE Dep med Exam M. D. or otherAddress Cherry Chase Md Date signed 4/11/48

MARGIN RESERVED FOR BINDING

VS A15 9-4-5-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 03994 714

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8409 Grove St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8409 Grove Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Pansy Rebecca Eslin

## 3.(b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Ernest G. Eslin

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

March 12, 1889

8. AGE:

Years

Months

Days

If less than one day

59023

hrs.

min.

9. Birthplace Halpine, Mont. Co., Maryland.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name George Mulligan13. Birthplace Layhill, Md.14. Maiden name Elizabeth Kemp15. Birthplace Mont. Co., Md.16. Informant Mr. Ernest G. EslinAddress 8409 Grove St., Silver Spring, Md.17. Burial Date thereof April 8, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Johns Catholic ChurchLocation Forest Glen, Maryland.18. Funeral director Warner E. HumphreyAddress 8434 Ga. Ave., Silver Spring, Md.19. Apr. 6 19 48 Josephine Schaeffle  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1948 at 12<sup>38</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 23, 1948 to 4-5-48 19and that I last saw her alive on 4-5-48 19

Immediate cause of death

Addison Disease on  
tuberculosis basis.

DURATION

2 yrs

Due to

Due to General cachexia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results confirmatory. (Tuberculosis chronic) Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Josephine Schaeffle M. D. or otherAddress Insurance Bank Bldg Date signed 4-5-48

RECEIVED

APR 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred: Suburban Hospital  
 How long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 8560 Locust Hill Rd.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war No

## 3. (a) FULL NAME

Dr. David J. Evans

## 3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, or divorced married  
 6. (b) Name of husband or wife Louise T. Evans  
 7. Birth date of deceased (mo., day, yr.) Oct. 17, 1872- 6. (c) If alive, give age 59 years  
 8. AGE: Years 75 Months 5 Days 20 If less than one day  
 hrs. min.

9. Birthplace Cambria, Wisc.  
 (town, county, and state)

10. Usual occupation M.D.

## 11. Industry or business

12. Name John R. Evans  
 13. Birthplace Wales  
 14. Maiden name Ann Evans  
 15. Birthplace Wales

16. Informant wife  
 Address same

17. Burial-Transit same Date thereof April 9, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lincoln Highway  
Aurora, Illinois  
 Location

18. Funeral director Wm. Hansen Humphrey  
 Address Bethesda, Maryland

19. April 9, 48 W.E. Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1948 at 8 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1947 to April 7, 1948  
 and that I last saw him alive on April 7, 1948

Immediate cause of death Broncho pneumonia DURATION 4 days

Due to Ant. cardiac decomposition 10 days

Due to Coronary thrombosis 11 days

Other conditions Generalized Arteriosclerosis 27 years

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

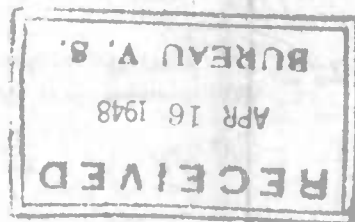
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Bruce T. Benjamin, M.D. M. D. or other  
Bethesda, Md. Address Date signed 4/8/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

63C

03996

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wash. Sam. Hosp.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. of C. County WashingtonCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 455 Riggs Rd NE.  
(If rural, give LOCATION)

2.(a) if veteran, name war

## 3.(a) FULL NAME

Donald Eugene Fagan

## 3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February 25, 1947

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1121

hrs.

min.

9. Birthplace

Takoma Park, Maryland  
(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

MOTHER  
FATHER

12. Name

John Albert Fagan

13. Birthplace

Washington, D.C.

14. Maiden name

Gladys Vlar

15. Birthplace

Virginia

16. Informant

John A. Fagan

Address

Washington, D.C.

17.

Burial

Date thereof

Apr. 19, 1948  
(month) (day) (year)

Cemetery or crematory

Wash. National Cemetery

Location

Prince Georges Co., Md.

18. Funeral director

W W Chambers Co.

Address

1400 Chapin St. N.W.

19.

(Write rec'd by registrar)

19

48

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/48 1948 at 10 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

4/15/48 1948 to 4/16/48 1948and that I last saw him unalive on 4/15/48 1948

Immediate cause of death

acute capillary Bron-  
chitis

DURATION

24 hrs

Due to

Tonsillitis2 days

Due to

Respiratory2 days

Other conditions

Cretinism  
CretinismInf

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 4/16/48

**RECEIVED**

APR 21 1948

**BUREAU V. S.**



RECEIVED

APR 17 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 03998 223

### 1. PLACE OF DEATH:

County MONTGOMERY  
City or town TAKOMA PARK 12, DD  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution:  
COLLIERS NURSING HOME  
805 MAPLE AVE. 2 1/2 mo.  
Stay in hospital or inst. (yrs., or mos., or days)  
Stay in this community (yrs., or mos., or days)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MAINE County \_\_\_\_\_  
City or town ORONA Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 2 SPENCER AVE  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR ☒

### 3. (a) FULL NAME

DOUGLAS FITZHERBERT

### 3. (b) Social Security Number

4. Sex MALE 5. Color or race WH 6. (a) Single, married, widowed, or divorced WIDOWED

### 8. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) APRIL 1, 1866  
8. AGE: Years 82 Months 0 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace FORT FAIRFED, MAINE  
(Town, county, and state)

10. Usual occupation REGISTERED NURSE

### 11. Industry or business

12. Name JAMES FITZHERBERT

13. Birthplace MAINE

14. Maiden name EXPERIENCE FITZHERBERT

15. Birthplace MAINE

16. Informant Edelaide C. Culver, R.N.

Address 805 Maple Ave. Montgomery

17. Removed Date thereof 4/23/98  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington

Location 26

18. Funeral director Hunterdon Funeral Home

Address 5734 Georgian Ave. N.W.

19. Apr-23 19. 48  
(Date rec'd by registrar)

Registrar J. M. Wood

### MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23 19 48 5:41 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/2 19 48 to 4/23 19 48  
and that I last saw him alive on 4/22 19 48

Immediate cause of death Lobar pneumonia  
cardiac failure

Due to arteriosclerotic heart disease

Due to also generalized atherosclerosis

Other conditions diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. J. [Signature] M. D. or other \_\_\_\_\_

Address 1741 R.I. Ave N.W. Date signed 4/23/98

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 28 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

03999

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? Dead on arrival

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Massachusetts County EssexCity or town Inswich  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3 Mt. Pleasant Avenue,

(If rural, give LOCATION)

2.(a) If veteran, name war World War II ✓

## 3. (a) FULL NAME

Thomas James Flynn, Jr.

## 3. (b) Social Security Number

Yes - Unknown

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Helen Sullivan

## 7. Birth date of deceased (mo., day, yr.)

June 14, 1908

## 8. AGE:

Years

Months

Days

If less than one day

3939104

hrs.

min.

## 9. Birthplace

Salem, Massachusetts

(Town, county, and state)

## 10. Usual occupation

Capt. U.S. Marine Corps

## 11. Industry or business

U.S. GovernmentFATHER  
MOTHER

## 12. Name

Thomas James Flynn, Sr.

## 13. Birthplace

Lawrence, Massachusetts

## 14. Maiden name

Celia A. Spain

## 15. Birthplace

Manchester, New Hampshire

## 16. Informant

Col. O. H. Wheeler

## Address

6505 Brennon Lane, Ch. Ch., Md.

## 17. Burial - Transit

(Burial, cremation, or removal. Which?)

Date thereof April 19, 1948  
(month) (day) (year)

## Cemetery or crematory

Inswich, Massachusetts

## Location

Inswich, Massachusetts

## 18. Funeral director

W. Reuben Humphrey

## Address

Bethesda, Maryland

## 19.

4/20/48  
(Date rec'd by registrar)48Wm E. Jones  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Apr 181948 at 8:30 P M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Self med. Exam case  
and that I last saw him alive on 19

## Immediate cause of death

Coronary occlusion

## DURATION

decided suddenly

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

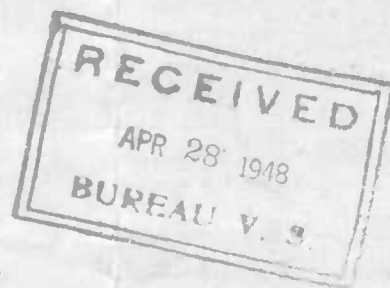
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Frank J. Bronckart M.D.  
Self med. Exam M. D. or other  
Address Washington Md. Date signed 4-18-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04000  
216  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 months, 7 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 2 months, 7 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 509 F St., N.E.  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Harry Martin FORD

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Pearl I. Ford  
7. Birth date of deceased (mo., day, yr.) March 10, 1899 6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 49 Months 0 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
(Town, county, and state)  
10. Usual occupation Retired (11 years)  
11. Industry or business Washington Terminal Railroad  
12. Name FORD, Harry H. dec. dec.  
13. Birthplace Md.  
14. Maiden name Margaret ? dec. dec.  
15. Birthplace Md.

16. Informant wife: Mrs. Pearl I. Ford  
Address 509 F St., N.E., Wash., D.C.  
17. burial Date thereof 4-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Arlington, Va.  
Location \_\_\_\_\_  
18. Funeral director Timothy HANLON  
Address 641 H. St. N.E. Washington, D.C.  
Mary C. Patterson  
19. 4-8 19 48 Mary C. Patterson Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 19 48 at 10:20P M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
17 February 19 48 to 8 April 19 48  
and that I last saw him alive on 8 April 19 48  
Immediate cause of death Broncho pneumonia  
Major item for statistics was Chronic Nephritis  
azotemia. 572445-9-5  
Septicemia  
Due to \_\_\_\_\_ DURATION 10 days  
Due to Chronic pyelonephritis  
and multiple Decubiti  
Other conditions Enlargement Prostate  
Clinical anemia  
(Include pregnancy within 3 months of death)  
Major findings of operations Fracture hip, 1944  
Date of op. \_\_\_\_\_  
Autopsy results no autopsy  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide acc. Date of Feb 1948  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) Home  
Means of injury Fall - due to Senile osteoporosis - Chr. acidosis  
L. E. Watters Jr.  
23. SIGNATURE L. E. WATTERS Jr., Lt. JG MC USN  
M. D. or other \_\_\_\_\_  
Address USNH Bethesda, Md. Date signed 4-8-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Montgomery  
Bethesda (rural)  
 City or town...  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 18 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 2 months, 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Washington, D. C. County...  
 City or town...  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1012 H St., N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... WWI ✓

## 3. (a) FULL NAME

FORD, Ralph

## 3. (b) Social Security Number

553 05 7290

4. Sex... male 5. Color or race... W-US 6. (a) Single, married, widowed, or divorced... married  
 6. (b) Name of husband or wife... Martha E. Ford  
 7. Birth date of deceased (mo., day, yr.)... May 27, 1894  
 8. AGE: Years... 53 Months... 5 Days... 24 If less than one day... hrs. ... min.

9. Birthplace... Michigan  
 (Town, county, and state)  
 10. Usual occupation... Barber  
 11. Industry or business...  
 12. Name... FORD, James M. dec.  
 13. Birthplace... Michigan  
 14. Maiden name... LOCKWOOD, Elma dec.  
 15. Birthplace... Michigan

16. Informant... wife: Mrs. Martha E. Ford  
 Address... 65 Carslie St., Uniontown, Pa.  
 17. burial Date thereof... 4-23-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Washington National Cem.  
 Location... Arlington, Virginia Washington, DC  
 18. Funeral director... W. W. CHAMBERS EMJ  
 Address... 1400 Chapin St., N.W., Wash., D.C.  
 19. 4-22 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 21 April 19 48 at 5:05 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
3 February 19 48 to 21 April 19 48  
 and that I last saw him alive on 21 April 19 48

Immediate cause of death... Carcinoma bronchogenic

Due to...  
 Due to...  
 Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations... same as above & generalized

Autopsy results... same as above & generalized metastases

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:  
 Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... H. R. COOPER, Lt. MC USN  
 M. D. or other

Address... USNH Bethesda, Md. Date signed... 4-22-48

RECEIVED

APR 23 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04002  
219

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Clarksburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Montgomery  
 City or town Clarksburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War I

## 3. (a) FULL NAME

Warren H. Foreman

## 3. (b) Social Security Number

m

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Joraine L. Foreman

## 7. Birth date of deceased (mo., day, yr.)

April - 29 - 1893

## 6. (c) If alive, give age

41 years

## 8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>11</u>	<u>20</u>	<u>—</u> hrs. <u>—</u> min.

## 9. Birthplace

Montgomery Co., Md.  
(Town, county, and state)

## 10. Usual occupation

farming  
Farm

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Wesley Foreman

## 13. Birthplace

Montgomery Co., Md.

## 14. Maiden name

Esther Warren

## 15. Birthplace

Montgomery Co., Md.

## 16. Informant

Joraine L. Foreman

## Address

Clarksburg, Md.

## 17. Burial

Burial Date thereof April 23 - 1948  
(Burial, cremation, or removal, which?) (month) (day) (year)

## 18. Cemetery or crematory

John Wesley

## 19. Location

Rock Hill Mt

## 20. Funeral director

W. W. Barber

## Address

Jeffersonville, Md.

## 21. Registrar

H. W. Bell

## Date rec'd by registrar

4/2348

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April - 20 - 1948 at 9 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 46 to April - 20 - 1948and that I last saw him live on April - 20 - 1948Immediate cause of death Pulmonary Tuberculosis

## DURATION

3 years

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

William C. Miller

M. D. or other

Address Jeffersonburg, Md. Date signed 4-20-48

RECEIVED

APR 27 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04003

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long is above place of death?... 3 months, 6 days  
 Hospital, institution, or exact address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long is hospital or institution?... 3 months, 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Va. County...  
 City or town... Alexandria  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1005 Oronoco St.  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

FUNN, James Lawrence

## 3. (b) Social Security Number

4. Sex... male 5. Color or race... Negro 6. (a) Single, married, widowed, or divorced... married  
 6. (b) Name of husband or wife... Lorraine B. Funn  
 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.)... September 13, 1891  
 8. AGE: Years... 56 Months... 6 Days... 23 If less than one day... hrs. min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 6 1948 at 11:30 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
30 December 1947 to 6 April 1948  
 and that I last saw him alive on 6 April 1948

Immediate cause of death... Bronchogenic, carcinoma

DURATION  
months

Due to...  
 Due to...  
 Other conditions...  
 (Include pregnancy within 3 months of death)

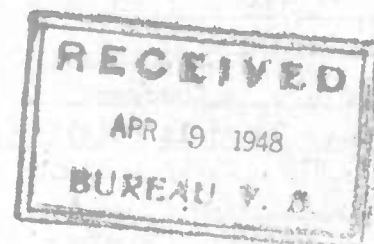
Major findings of operations...  
 Date of op...

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... R. N. Shelley  
R. N. SHELLEY, Cor. MC USN  
 M. D. or other  
 Address... USNH Bethesda, Md. Date signed... 4-7-48

9. Birthplace... Virginia  
 (Town, county, and state)  
 10. Usual occupation... Checker  
 11. Industry or business... Cocacola Bottling Works  
 12. Name... FUNN, James Lawrence dec.  
 13. Birthplace... Va.  
 14. Maiden name... MARTIN, Ann Rosa dec.  
 15. Birthplace... Va.  
 16. Informant... wife: Mrs. Lorraine B. Funn.  
 Address... 1005 Oronoco St., Alexandria, Va.  
 17. burial Date thereof... 4-9-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Arlington National  
 Location... Arlington, Va.  
 18. Funeral director... McGuire Funeral Home  
 Address... 1820 9th St. N.W., Washington, D.C.  
 19. 4-7- 1948 Mary C. Patterson  
 (Date rec'd by registrar) Registrar



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

### 1. PLACE OF DEATH:

County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 822 Heron Dr  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Leroy B Galer

### 3. (b) Social Security Number

577-07-5680

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sadie A Galer

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 27 - 1879

8. AGE: Years 68 Months 8 mo Days 22 It less than one day  
hrs. min.

9. Birthplace Washington DC  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Brooks Galer

13. Birthplace Montgomery Co Md

14. Maiden name Mrs. Hurley

15. Birthplace Wash DC

16. Informant Mrs Sadie Galer

Address 822 Heron Dr.

17. Burial Date thereof April 22 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Bladensburg, Md.

16. Funeral director Warner E. Humphrey

Address 8434 Ga. Ave. Silver Spring, Md.

19. April 20 19 48 Josephine Schaeff  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 19 19 48 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 19 48 to Apr 19 19 48  
and that I last saw him alive on Apr 12 19 48

Immediate cause of death Heart failure DURATION 4 mo

Due to Cardio-renal vascular disease 4 yrs

Due to  
Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Coulson MD M. D. or other  
Address 3100-25 NE DC Date signed 4/19/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04005

Reg. Dist. No. 414

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

22 Melbourne Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 22 Melbourne Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

JOHN C. GIBSON

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of ~~husband~~ or wife Clara Allan Gibson

7. Birth date of

deceased (mo., day, yr.)

April 15, 1880

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

6808

hrs.

min.

9. Birthplace Bradford, Pa.

(Town, county, and state)

10. Usual occupation Mining Engineer

11. Industry or business

12. Name William Gideon Gibson13. Birthplace Armstrong, Pa.14. Maiden name Elizabeth Hutchinson15. Birthplace Armstrong, Pa.16. Informant Mrs. Frederick W. Howard, daughterAddress 22 Melbourne Ave., Silver Spring, Md.17. Shipment & burial Date thereof Apr. 23, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory I. O. O. F. CemeteryLocation DuQuoin, Perry County, Illinois18. Funeral director Waxner E. Pumphrey, Inc.Address 8434 Ga. Ave., Silver Spring, Md.19. Apr. 43 19 48 Josephine Schaeffer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 23 APRIL 1948 at 1205A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 MARCH 1948, to 23 APRIL 1948and that I last saw him alive on 23 APRIL 1948Immediate cause of death CEREBRAL HEMORRHAGE, MASSIVE

DURATION

30 MINDue to HYPERTENSION, ARTERIALC HYPERTENSIVE HEART DISEASE2 MO.Due to GENERALIZED ARTERIO-SCLEROSISUNK.Other conditions RESIDUALS OF PREVIOUS CEREBRAL HEMORRHAGE

(Include pregnancy within 3 months of death)

Major findings of operations NONEDate of op. —Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

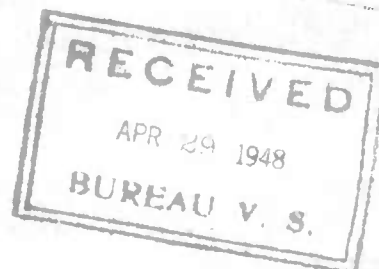
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Marshall Gwilielms, MD

M. D. or other

Address 8648 GEORGIA AVE. Date signed 23 APR. 48SILVER SPRING, MD



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04006 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 hours, 40 minutes  
 Hospital, institution, or street address where death occurred:  
Suburban Hosp. 8600 Georgetown Rd.  
 How long in hospital or institution? 4 hours, 40 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Dist. of Col. County \_\_\_\_\_  
 City or town Washington, D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3000 39th St., N.W.  
 (If rural, give LOCATION) ☒

## 3. (a) FULL NAME

Mr. Archie A. Gillis

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Gladys A. Gillis

## 7. Birth date of deceased (mo., day, yr.)

Feb. 27, 1885

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

6317hrs. min.

## 9. Birthplace

Boston, Massachusetts  
(Town, county, and state)

## 10. Usual occupation

lawyer

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Daniel Gillis Duncan

## 13. Birthplace

Nova Scotia, Canada

## 14. Maiden name

Margaret McPhee

## 15. Birthplace

Nova Scotia, Canada

## 16. Informant

## Address

Burial

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

April 6, 1948  
(month) (day) (year)

## Cemetery or crematory

Forest Hill Cemetery

## Location

Boston, Mass.

## 18. Funeral director

Shaw Co

## Address

2901-14th St N.W.

## 19.

(Date read by registrar)

April 4, 194827 M E J  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1948 3:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 19, 1948, to 4/4, 1948  
and that I last saw him alive on 4/4, 1948

Immediate cause of death

Primary thrombosis & myocardial infarction

DURATION

6 hours

Due to

Primary insufficiency due to coronary arteriosclerosisseveral years

Due to

Other conditions

Botic sclerosis with clot in descending aorta.  
(Include pregnancy within 3 months of death)years -

Major findings of operations

None

Date of op. \_\_\_\_\_

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'l'c place (where?)

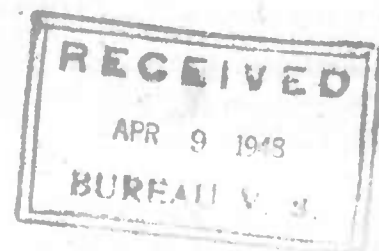
Means of injury

Injured at work?

23. SIGNATURE

Edward M. J.Address 1726 Eye St. N.W. Washington M. D. or other 4/4/48  
Date signed \_\_\_\_\_







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. <sup>Incorrect age</sup> is especially important. Physicians: please write the causes of death clearly and legibly. <sup>H</sup>

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

83a

not to

04007

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rural (Lewisdale)  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FredrickCity or town Morronia  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

CHARLES CLEVELAND GUE

## 3. (b) Social Security Number

2

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife FRANCES M. GUENov. 6, 18706. (c) If alive, give age 71 years

## 7. Birth date of

deceased (mo., day, yr.)

1870

## 8. AGE:

Years

Months

Days

If less than one day

7754

hrs.

min.

## 9. Birthplace:

hr. LewisdaleMontgomery

(Town, county, and state)

Maryland

## 10. Usual occupation:

farmer

## 11. Industry or business

farm

## FATHER

## 12. Name

Lorenzo Gue.

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Carrie Amberson

## 15. Birthplace

Maryland

## 16. Informant

Wife

## Address

Amre

## 17.

(Burial, cremation, or removal, Which?)

Date thereof

Tues. 13/1948

## Cemetery or crematory

Mount Olivet

## Location

Fredrick Maryland

## 18. Funeral director

L. G. Belinet Son.

## Address

Fredrick Maryland

## 19.

(Date rec'd by registrar)

April 10, 1948 Della W. Burdett

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 April 19 48 at 7 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Apr 19 48 to 10 Apr 19 48 and that I last saw him alive on 10 - Apr 19 48

## Immediate cause of death

Cerebral Vascular accident

## Due to

Arteriosclerosis

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

## Means of injury

Injured at work?

## 23. SIGNATURE

Cheer RandolM.D.Address Damascus Md. Date signed 10 Apr. 48

RECEIVED

APR 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery Co.City or town Bethesda Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since 4-8-48 - 6 P.M.Hospital, institution, or street address where death occurred: Suburban Hosp  
8600 Old Georgetown Rd. Bethesda Md.How long in hospital or institution? Since 4-8-48 - 6 P.M.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County \_\_\_\_\_City or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rockville md, County 4 Home  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Harkins

## 3. (b) Social Security Number

## 4. Sex

m

## 5. Color or race

w

## 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Clara Harkins (Dec)

## 7. Birth date of

deceased (mo., day, yr.) Jan, 14, 1866

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

82226

hrs.

min.

9. Birthplace Compass Pennsylvania  
(Town, county, and state)

## 10. Usual occupation \_\_\_\_\_

## 11. Industry or business \_\_\_\_\_

## FATHER

## 12. Name

?Harkins (?)

## 13. Birthplace

?

## MOTHER

## 14. Maiden name

?Springer

## 15. Birthplace

?16. Informant Raymond HarkinsAddress 8401 Bladenburg Rd S.E.17. Burial  
(Burial, cremation, or removal. Which?)Date thereof April 13 1948  
(month) (day) (year)

## Cemetery or crematory

Geo. Washington Memorial Cemetery

## Location

Riggs Rd. Hyattsville, Md.

## 18. Funeral director

J. Arthur Walters

## Address

254 Carroll St NW Tok Park DC19. 4/11 19 48  
(Date rec'd by registrar)Wm E Jones  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10-48 19 48, at 2 12 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 April 19 48, to 10 April 19 48  
and that I last saw him alive on 10 April 19 48

## Immediate cause of death

malnutrition  
Senility.

## DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

## Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

## Autopsy results

Refused.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

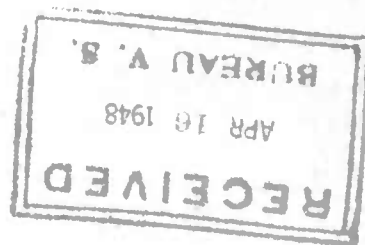
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. E. Jones, M.D.

M. D. or other

Address \_\_\_\_\_ Date signed \_\_\_\_\_

518 Major Lloyd L. W. 5875



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Pa. County \_\_\_\_\_  
 City or town Pittsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7431 Tioga Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI ✓

## 3. (a) FULL NAME

HAROVER, John Thomas

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) June 17, 1894 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 53 Months 9 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mo. (Town, county, and state)  
 10. Usual occupation Shop worker & or duty in hospital  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name HAROVER, John T.  
 13. Birthplace Ky.  
 MOTHER 14. Maiden name PATTERSON, Gennie  
 15. Birthplace Ireland

16. Informant brother: Mr. Arthur Harover  
 Address 7431 Tioga St., Pittsburg, Pa.  
 17. burial Date thereof 4-9-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National Cemetery  
 Location Arlington, Virginia

18. Funeral director W. W. Chambers Co. A. P.  
 Address 1400 Chapin St., NW, Washington, D.C.

19. 4-7- 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 April 19 48 at 8:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 April 19 48 to 6 April 19 48  
 and that I last saw h im alive on 6 April 19 48

Immediate cause of death Lobar Pneumonia DURATION 3 days

Due to Malnutrition 6 mos.

Due to Septicemia, Type Seven 48 hrs.  
Pneumococcus

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. R. COOPER, Lt. MC USN

Address USNH Bethesda, Md. M. D. or other 4-7-48  
 Date signed \_\_\_\_\_



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mildred

7. Birth date of

deceased (mo., day, yr.)

Nov-17, 1902-

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

4557

hrs.

min.

9. Birthplace

Barrington Township, N.Y.  
(Town, county, and state)

10. Usual occupation

Manager

11. Industry or business

weighing & Research Bureau

MOTHER FATHER

12. Name

Richard Hathaway

13. Birthplace

Barrington, N.Y.

14. Maiden name

Mabel Stanton

15. Birthplace

Barrington, N.Y.

18. Informant

wife

Address

same

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

April 28, 1948  
(month) (day) (year)

Cemetery or crematory

Lakeview Cemetery

Location

Penn Yan, New York

18. Funeral director

W. R. R. Humphrey

Address

Bethesda, Maryland

19.

(Date rec'd by registrar)

19.

48

19.

48

19.

48

19.

48

19.

48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Rockville  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

R.T.D. #5  
(If rural, give LOCATION)

2. (a) If veteran, name war

No

## 3. (b) Social Security Number

076-10-8930

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 24, 1948 at 7:43 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 to April 24, 1948

and that I last saw him alive on

April 24, 1948

Immediate cause of death

Coronary thrombosis

DURATION

2 days

Due to

Myocardial attacks 1943

Due to

1947

Other conditions

Coronary arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

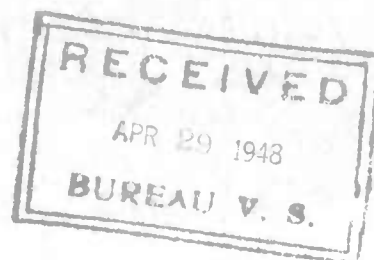
23. SIGNATURE

W. R. R. Humphrey M.D.

M. D. or other

Address

Rockville, Md.Date signed 4/24/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04011 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months, 5 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 5 months, 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3427 13th St., N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWII ✓

## 3. (a) FULL NAME

HELVESTINE, Roy Theodore

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Ella Helvestine  
 7. Birth date of deceased (mo., day, yr.) April 21, 1898 8.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 49 Months 11 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation Baker  
 11. Industry or business \_\_\_\_\_  
 12. Name HELVESTINE, William T.  
 13. Birthplace Va.  
 14. Maiden name Florence ?  
 15. Birthplace Va.

16. Informant wife: Mrs. Ella Helvestine  
 Address 3427 13th St., N. W., Wash., D.C.  
 17. burial Date thereof 4-12-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill  
 Location Washington, D. C.  
 18. Funeral director S. H. HINES Accra  
 Address 2901 14th St., N.W., Wash., D.C.  
 19. 4-9- 1948 Mary G. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 19 48, at 11:45 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 November 47 to 8 April 19 48  
 and that I last saw him alive on 8 April 19 48

Immediate cause of death Hemorrhage (Intestinal) DURATION days

Due to Carcinoma of Sacral bladder Months

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE J. A. MURPHY, Cdr. MC USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 4-9-48

RECEIVED

APR 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04012

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 745 Thayer Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Dorothy Kramer Henderson

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Walter A. Henderson7. Birth date of deceased (mo., day, yr.) Sept. 3, 1899 6.(c) If alive, give age years8. AGE: Years 48 Months 7 Days 13 If less than one day hrs. min.9. Birthplace Washington, D.C.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John C. Kramer13. Birthplace Maryland14. Maiden name Ida Maria Duley15. Birthplace Washington, D.C.16. Informant Mr. Walter A. HendersonAddress 745 Thayer Ave. Silver Spring17. Burial Date thereof April 19, 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort LincolnLocation Bladensburg, Md.18. Funeral director Walter E. RumphreyAddress 8434 Ga. Ave., Silver Spring, Md.19. Apr. 18 19 48 Josephine Schaeffe  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Apr. 19 48 at 1:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12, 19 46, to 16 Apr. 19 48and that I last saw him alive on 16 Apr. 19 48

Immediate cause of death

DURATION

Hodgkin's Disease 8-9 yrs.

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

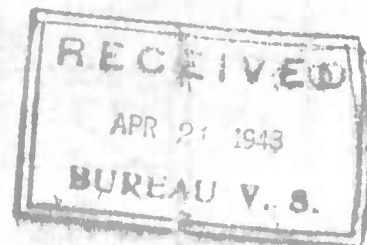
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.B. Zeller M. D. or otherAddress Saltown Post, Md. Date signed 18 Apr. 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04013

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

10,101 Pierce Drive.

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10,101 Pierce Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Hans St. L. Hiedemann

## 3. (b) Social Security Number

4. Sex male5. Color or race White

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Natalie7. Birth date of deceased (mo., day, yr.) August 24, 1862

6. (c) If alive, give age .....

8. AGE: Years 85 Months 8 Days 4 If less than one day

.....hrs. ....min.

9. Birthplace Cologne, Germany

(Town, county, and state)

10. Usual occupation Retired

## 11. Industry or business

12. Name Jean Hiedemann13. Birthplace Germany14. Maiden name Gertrud Hasselsweiler15. Birthplace Germany16. Informant Egon HiedemannAddress 10,101 Pierce Dr. Silver Spring17. Burial May 1, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington Memorial ParkLocation Riggs Rd. Prince George Co.18. Funeral director Wm. E. Humphrey, Inc.Address 8434 Ga. Ave., Silver Spring, Md.19. Apr. 5, 1948 Josephine Schoeffe

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 28 1948, at 5a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 13 1948 to Apr 27 1948and that I last saw him alive on Apr 27 1948Immediate cause of death Cerebral hemorrhage

DURATION

4 monthsDue to Hypertensiontwenty years

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? .....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work? .....

23. SIGNATURE John N. Andrews, M.D.Address Silver Spring, Md.Date signed 4-28-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAINE STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DEPARTMENT OF HEALTH

IN THE DEPARTMENT OF HEALTH

RECEIVED  
MAY 1 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04014

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rural near Grantlakh  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred: \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Montgomery  
 City or town Grantlakh  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Annie Joseph Hill

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife James H. Hill  
 6. (c) If alive, give age 44 years  
 7. Birth date of deceased (mo., day, yr.) July - 1 - 1908  
 8. AGE: Years 39 Months 9 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Montgomery Co., Md.  
 (Town, county, and state)  
 10. Usual occupation house-keeping  
 11. Industry or business at home  
 12. Name Samuel J. Fowle  
 13. Birthplace Montgomery Co., Md.  
 14. Maiden name Annie Margaret Bolton  
 15. Birthplace Montgomery Co., Md.  
 16. Informant Catherine Mary Hill  
 Address Gaithersburg, Md - Route 3  
 17. Final Burial Date thereof 4/13/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Forest Oak Cemetery  
 Location Gaithersburg, Md  
 18. Funeral director P. G. Gachue  
 Address Gaithersburg, Md  
 19. April 2 19 48 Abraham L. Corde  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April - 1 - 1948 at 5 A - M  
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from \_\_\_\_\_ 1946 to April - 1 - 1948  
 and that I last saw her alive on March - 31 - 1948  
 Immediate cause of death Cerebral hemorrhage DURATION 12 hours  
 Due to High arterial tension 2 1/2 yrs  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE William C. Miller, M.D.  
 M. D. or other \_\_\_\_\_  
 Address Gaithersburg, Md Date signed 4-1-48



**RECEIVED**

APR 5 1948

**BUREAU V. S.**



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04015

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County MontgomeryCity or town Emory Grove  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Emory Grove  
(If outside city or town limits, write RURAL and give nearest town)Street No. East Hershburg, Md  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

James M. Holland

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Ollie Holland6. (c) If alive, give age 36 years

## 7. Birth date of deceased (mo., day, yr.)

December 31, 1910

## 8. AGE:

38

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

Emory Grove, Montgomery, Md  
(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

## MOTHER

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17.

(Burial, cremation, or removal, Which?)

Date thereof April 17, 1948  
(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 13 1948 at 8:26 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med exam case 1948 to 19  
and that I last saw him alive on 1948

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address East Hershburg, Md Date signed 4-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04016

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
8248 Georgia Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 731 Sligo Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

WILBER C. HOOD

## 3. (b) Social Security Number

214-03-8185

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Myrtle V. Hood

## 7. Birth date of deceased (mo., day, yr.)

April 13, 1903

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

It less than one day

4506

hrs.

min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Auto Mechanic

## 11. Industry or business

Own BusinessFATHER  
MOTHER

## 12. Name

Marion Eugene Hood

## 13. Birthplace

Maryland

## 14. Maiden name

Emma F. Crawford

## 15. Birthplace

Maryland

## 16. Informant

Mrs Myrtle V. Hood

## Address

731 Sligo Ave., S.S. Md.

## 17.

Burial

## Date thereof

April 22- 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Mt. Olivet

## Location

Frederick, Maryland.

## 18. Funeral director

Wm. C. Humphrey

## Address

8434 Ga. Ave. Silver Spring, Md.

## 19.

April 20  
(Date rec'd by registrar)

19

48 Josephine Schaeff  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 191948 at 3:30 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med exam case  
and that I last saw h..... alive on..... 19.....

## Immediate cause of death

## DURATION

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

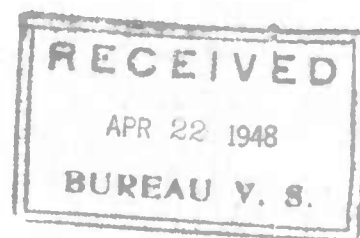
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Frank J. Bronckart M.D.Def med exam, M. D. or otheraddress Garthburg Md Date signed 3-19-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04017

Reg. Dist. No. 216

1. PLACE OF DEATH: **Montgomery**  
 County.....  
 City or town..... **Bethesda (rural)**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **9 days**  
 Hospital, institution, or street address where death occurred:  
**U. S. NAVAL HOSPITAL, Bethesda, Md.**  
 How long in hospital or institution?..... **9 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... **Md.**..... County..... **PG**  
 City or town..... **Bladensburg**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... **Post Office**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... **WWI** ✓

3. (a) FULL NAME  
**HOPKINS, Charles Edward Jr.**

3. (b) Social Security Number

4. Sex..... **Male**  
 5. Color or race..... **Col**  
 6. (a) Single, married, widowed, or divorced..... **divorced**  
 6. (b) Name of husband or wife..... **Nellie Hopkins**  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... **July 26, 1899**  
 8. AGE: Years..... **48** Months..... **7** Days..... **2** If less than one day..... hrs. .... min.

9. Birthplace..... **Penna.**  
 (Town, county, and state)  
 10. Usual occupation..... **Carpenter**  
 11. Industry or business.....  
 12. Name..... **HOPKINS, Charles E. Sr.**  
 13. Birthplace..... **Pa.**  
 14. Maiden name..... **FRY, Ada,**  
 15. Birthplace..... **Pa.**

16. Informant..... **mother: Mrs. Ada L. Hopkins**  
 Address..... **347 Lafayette Avenue, Brooklyn, N.Y.**  
 17. **burial**  
 (Burial, cremation, or removal. Which?) Defs thereof..... **5-3-48**  
 (month) (day) (year)  
 Cemetery or crematory..... **Arlington National**  
 Location..... **Arlington, Virginia**  
 18. Funeral director..... **Melvin & Schey R. A. W.**  
 Address..... **424 R St., N. W. Washington, D. C.**  
 19. **4-29** **48** **Mary C. Patterson**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **28 April** 19 **48**, at **3 P.** M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**19 April** 19 **48**, to **28 April** 19 **48**  
 and that I last saw him alive on **28 April** 19 **48**

Immediate cause of death..... **Shock due to anaesthetic**

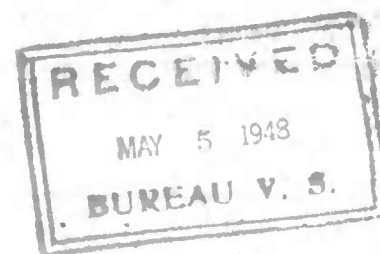
~~XXXX~~ **Mastoiditis, Chronic, left**  
**and right ears**  
~~XXXX~~ **Paralysis, right side of face**

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results..... **confirmed above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... **AB Delaney** injured at work?

23. SIGNATURE..... **A. J. DELANEY, Capt. MC USN**  
 M. D. or other  
 Address..... **USNH Bethesda, Md.** Date signed **4-29-48**



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 04018 2/3

### 1. PLACE OF DEATH:

County Montgomery  
City or town Lincoln Park, Rockville, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Lincoln Park, Rockville, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

Mary L. Howard

### 3.(b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Colored Married

6.(b) Name of husband or wife Frederick Howard

7. Birth date of deceased (mo., day, yr.) February 28, 1876 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Frederick Co. Virginia  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER  
12. Name Jalm Wood  
13. Birthplace Elmore Co. Va  
14. Maiden name Polly Johnson  
15. Birthplace Elmore Co. Va

16. Informant Frederick Howard

Address Rockville, Md.

17. Burial Date thereof April 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lincoln Park

Location Rockville, Md.

18. Funeral director Robert L. Snowden

Address Rockville, Md.

19. 4-13 48 SP Thompson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 48 1:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 19 to April 9, 19 48

and that I last saw her alive on April 9, 19 48

Immediate cause of death Chronic myocarditis & Chronic nephritis

### DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic cholecystitis

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. E. Hawkes MD

Address Rockville Md M. D. or other \_\_\_\_\_  
Date signed 4/12/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED  
APR 14 1948  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery County  
City or town Takoma Park, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 hrs 45 min.Hospital, institution, or street address where death occurred:  
Washington San & Hosp Takoma ParkHow long in hospital or institution? 20 hrs 45 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 761 Silver Spring Ave Rd  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs Florence Marie Howell.

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

Mr H. Ray Howell.

## 7. Birth date of

deceased (mo., da., yr.)

March 28 - 1900

## 6. (c) If alive, give age

48 years

## 8. AGE:

Years

Months

Days

If less than one day

4848

hrs.

45 min.

## 9. Birthplace

Richmond, Va.  
(Town, county, and state)

## 10. Usual occupation

House wife.

## 11. Industry or business

## FATHER

## 12. Name

Frank A. Sherman

## 13. Birthplace

Germany.

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

Va.

## 16. Informant

Hosp Records.

## Address

Washington San & Hosp.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

Apr. 3 - 1948

(month) (day) (year)

## Cemetery or crematory

Oakwood Cemetery

## Location

Richmond Va.

## 18. Funeral director

W. W. Chambers Co.

## Address

1400 Chapel St. N. W. Wash. D. C.

## 19.

(Date rec'd by registrar)

Apr. 2 - 48

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2- 1948 at 9:52 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-17- 1947 to 4-2- 1948and that I last saw her alive on 4-2- 1948

## Immediate cause of death

Acute myocardial failure

## DURATION

22 hrs

## Due to

chronic mitral and aortic valvular disease16 yrs

## Due to

Rheumatic fever.18 years

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

none

Date of op.

Autopsy results as above - done 4-2-48

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

W. W. Chambers

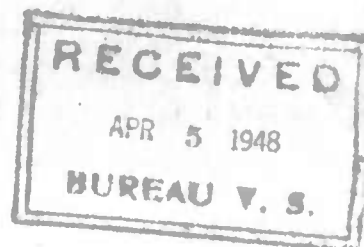
M. D. or other

Address 8045 Woodbury Dr. Silver Spring, Md. Date signed 4/2/48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 5 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04020 223

### 1. PLACE OF DEATH

County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 hrs.  
Hospital, institution, or street address where death occurred:  
Washington Sanitarium and Hosp.  
How long in hospital or institution? 6 hrs.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route 1  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Unnamed Baby Boy Jacquot

### 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced  
6. (b) Name of husband or wife  
7. Birth date of deceased (mo., day, yr.) Apr. 11, 1948  
8. AGE: Years Months Days If less than one day  
5 hrs. 50 min.

9. Birthplace Takoma Park, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Victor John Jacquot  
13. Birthplace Leavenworth, Kansas

MOTHER 14. Maiden name Ruth Virginia Dingman  
15. Birthplace Beewyn, Md.

16. Informant Washington Sanitarium Records  
Address Takoma Park, Md.

17. Cremation Date thereof 4-11-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Washington Sanitarium Hosp.  
Takoma Park, Md.  
Location

18. Funeral director We have permission from  
Address parents, Washington Sanitarium Hosp.  
Takoma Park, Md.

19. 4/11 19 48  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 11, 1948 at 8:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
4-11-48 to 4-11-48  
and that I last saw him alive on 4-11-48

Immediate cause of death Prenatal death  
6 mo. gestation

Due to circumvallate placenta

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Emma Hughes, M.D.  
M. D. or other  
Address Takoma Park, Md. Date signed 4-11-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Evidence for change of

Mother's name shown on:

MAY NO. 6 11 MAY 7 - 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 04021 216

1. PLACE OF DEATH: Montgomery  
 County.....  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months, 9 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 3 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... Washington, County.....  
 City or town..... District of Columbia  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4910 Livingston Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWII

3. (a) FULL NAME

JOHNSON, Lewis Jr.

3. (b) Social Security Number

577-07-7088

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Katherine M. Johnson  
 6. (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) October 24, 1913  
 8. AGE: Years 34 Months 5 Days 27 If less than one day ..... hrs. .... min.

8. Birthplace..... Virginia  
 (Town, county, and state)  
 10. Usual occupation..... unknown  
 11. Industry or business.....  
 FATHER 12. Name..... JOHNSON, Lewis Sr.  
 13. Birthplace.....  
 MOTHER 14. Maiden name..... FURR, Esther L.  
 15. Birthplace.....

16. Informant..... wife: Mrs. Katherine M. Johnson  
 Address 4910 Livingston Road, S.E., Wash., D.C.  
 17. burial Date thereof 4-23-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National  
 Location..... Arlington, Virginia  
 18. Funeral director..... W. W. CHAMBERS  
 Address 517 11th St., S.E., Wash., D.C.  
Mary C. Patterson  
4-21 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 21 19 48 at 3:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
12 January 19 48 to 21 April 19 48  
 and that I last saw h. in alive on 21 April 19 48

Immediate cause of death.....  
Tumor, mixed, malignant  
mediastinum

DURATION  
indef.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results..... same as above & Generalized metastases

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... L. E. Watters  
E. E. WATTERS, Lt. JG USN

M. D. or other

Address..... USNH Bethesda, Md. Date signed 4-21-48

RECEIVED

APR 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5327 Belt Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI ✓

## 3. (a) FULL NAME

Sol L. Kasdon KASDON, Sol Louis

## 3. (b) Social Security Number

4. Sex male 5. Color or race Jewish 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Sarah Kasdon  
 7. Birth date of deceased (mo., day, yr.) October 13, 1888  
 8. AGE: Years 59 Months 5 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Russia  
 (Town, county, and state)  
 10. Usual occupation Stock Salesman  
 11. Industry or business Herrick Waddell Co.  
 12. Name KASDON, Louis dec.  
 13. Birthplace Russia  
 14. Maiden name GOLDEN, Rose dec.  
 15. Birthplace Russia

16. Informant wife: Mrs. Sarah Kadson  
 Address 5327 Belt Road, Washington, D. C.  
 17. burial Date thereof 4-6-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Virginia  
 18. Funeral director DANZANSKY  
 Address 3510 14th St. NW, Washington, D.C.  
 19. 4-4-48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4 April 19 48 at 7:15 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 March 19 48, to 4 April 19 48,  
 and that I last saw him alive on 4 April 19 48.

Immediate cause of death  
Carcinoma of sigmoid with metastasis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. A. MURPHY, Cdr. MC USN  
 M. D. or other \_\_\_\_\_Address USNH Bethesda, Md. Date signed 4-4-48

RECEIVED

APR 6 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04023

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 days  
 Hospital, institution, or street address where death occurred:  
U.S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Washington, D. C. County Washington, D. C.  
 City or town Washington, D. C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3417 Sherman Avenue, N.W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war ✓

## 3. (a) FULL NAME

KEYS, Samuel Andrew

## 3. (b) Social Security Number

4. Sex male 5. Color or race Col-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Minnie S. Keys  
 6. (c) If alive, give age 19 years  
 7. Birth date of deceased (mo., day, yr.) February 25, 1877  
 8. AGE: Years 71 Months 1 Days 19 If less than one day hrs. min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation unknown  
 11. Industry or business

FATHER 12. Name KEYS, John  
 13. Birthplace Va.  
 MOTHER 14. Maiden name HARRIS, Alice  
 15. Birthplace Va.

16. Informant wife: Mrs. Minnie S. Keys  
 Address 3417 Sherman Avenue, N.W., Wash., D.C.  
 17. burial Date thereof 4-19-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.

18. Funeral director McGuire Funeral Home J. G. W.  
 Address 1820 9th St., N.W., Wash., D.C.

19. 4-15 19 48 Mary Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 19 48 at 2:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 April 19 48 to 14 April 19 48 and that I last saw him alive on 14 April 19 48

Immediate cause of death Rupture, nontraumatic, myocardium

Due to Thrombosis coronary DURATION 8 days

Due to 1-3-48

Other conditions Bronchopneumonia 1 wk

(Include pregnancy within 3 months of death)

Major findings of operations same as above

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide same as above Date of 4-19-48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury H. R. COOPER, Lt. MC USN Injured at work?

23. SIGNATURE H. R. COOPER, Lt. MC USN  
 M. D. or other

Address USNH Bethesda, Md. Date signed 4-15-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County..... MONTGOMERY  
 City or town..... OLNEY  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 29 days  
 Hospital, institution, or street address where death occurred:  
MONTGOMERY COUNTY GENERAL HOSPITAL  
 How long in hospital or institution?..... 29 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Montgomery  
 City or town..... Faithsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... no.

## 3. (a) FULL NAME

CHRISTOPHER KISNER

## 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Male White widowed

6. (b) Name of husband or wife..... Isabelle

7. Birth date of deceased (mo., day, yr.)..... 6. (c) If alive, give age..... years  
1851

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.  
97

9. Birthplace..... Maryland  
 (Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business.....

12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... Hospital records

Address.....

17. Layhill Church Cemetery Date thereof..... May 2 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Layhill Church Cemetery

Location..... Maryland

18. Funeral director..... Wm Reuben Humphrey

Address..... Bethesda, Maryland

19. Edgar 30 19 48 Bertine B Zander  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 29 19 48 at 9 05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 19 48 to April 29 19 48 and that I last saw him alive on April 29 19 48

Immediate cause of death..... Cellulitis with Trophic Ulcers

RT leg..... 5 weeks  
 Due to..... Generalized arteriosclerosis ? years

Due to.....

Other conditions..... Arteriosclerotic Heart Disease ? yrs.

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

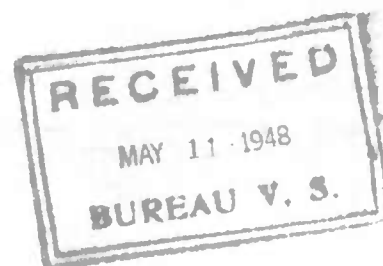
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... JMB:1 M. D. or other

Address..... Sandy Spring, Md Date signed..... 4/30/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04025 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Fabulous Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Washington Sanatorium & HospitalHow long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_

City or town WASHINGTON DC  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1239 GOOD HOPE RD. S.E.  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

FRANK KLAWANS

## 3. (b) Social Security Number

4. Sex male5. Color or race white6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 15, 18718. AGE: Years 76 Months 11 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Lithuania, Europe  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Samuel Klawans13. Birthplace Pakoy, Lithuania14. Maiden name Leah or Sarah (last name unknown)15. Birthplace Lithuania16. Informant Washington Sanatorium RecordsAddress Fabulous Park, Md17. Burial Date thereof Apr. 18, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ohev Shalom Cem.Location Washington DC18. Funeral director B. Damsky & SonAddress 3501-14th St. NW19. April 16 19 48 William Bell  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 16 19 48, at 1:30 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 19 47 to Apr 16 19 48and that I last saw him alive on Apr 16 19 48

Immediate cause of death

Acute Cardiac Failure

DURATION

Due to Peritonitis & ToxemiaDue to Acute Appendicitis

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operation

Peritonitis Date of op. 4-11-48

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dean H. Harding MD M.D. or otherAddress 113 Carroll St NW Date signed 4-16-48  
Wash DC

RECEIVED

APR 21 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04026  
216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 46 years  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Kensington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 19 W. Washington, St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No

## 3. (a) FULL NAME

Benjamin W. Kumler

## 3. (b) Social Security Number

220-12-3559

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Eva C. Kumler  
 7. Birth date of deceased (mo., day, yr.) January 14, 1866 6.(c) If alive, give age 75 years  
 8. AGE: Year 82 Months 82 Days 2 If less than one day 22 hrs. 22 min.

9. Birthplace Walbash, Indiana  
 (Town, county, and state)  
 10. Usual occupation Secretary Montg. Mutual  
 11. Industry or business None

12. Name Franklin W. Kumler  
 13. Birthplace Dayton, Ohio  
 14. Maiden name Mary E. Flickinger  
 15. Birthplace Millville, Ohio

16. Informant Melvin C. Kumler  
 Address Kensington, Maryland

17. Removal Date thereof Apr 8, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethesda Funeral Home  
 Location Bethesda, Maryland

18. Funeral director Wm. Landon Sampson  
 Address Bethesda, Maryland

19. 4/8 19 48 W.E. Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1948 at 3:22P M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 19 48, to April 6 19 48  
 and that I last saw him alive on April 6 19 48

Immediate cause of death Pneumonia  
 DURATION 1 week

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Generalized arteriosclerosis  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Marion Bausch MD M. D. or other  
83601 Sutton Rd  
 Address Silver Spring, MD Date signed 4/6/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

APR 13 1948

**BUREAU V. S.**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

04027

216

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 6 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution?..... 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Virginia County.....  
 City or town..... Falls Church  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Box 1045  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... Sp-Am. & WWI ✓

## 3. (a) FULL NAME

LANE, Rufus Herman, Brig. General USMC Ret.

## 3. (b) Social Security Number

4. Sex..... male 5. Color or race..... W-US 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Gertrude M. Lane  
 7. Birth date of deceased (mo., day, yr.)..... October 31, 1870 6.(c) If alive, give age..... years  
 8. AGE: Years..... 77 Months..... 5 Days..... 19 If less than one day..... hrs. .... min.

9. Birthplace..... Ohio  
 (Town, county, and state)  
 10. Usual occupation..... Retired Marine Corps  
 11. Industry or business.....  
 FATHER 12. Name..... LANE, Issad Richard dec.  
 13. Birthplace..... Ohio  
 MOTHER 14. Maiden name..... WARFIELD, Mary dec.  
 15. Birthplace..... Ohio

16. Informant..... wife: Mrs. Gertrude M. Lane  
 Address..... Box 1045, Falls Church, Virginia  
 17. burial Date thereof..... 4-23-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National  
 Location..... Arlington, Virginia  
 18. Funeral director..... Joseph GAWLER Sons J. Arlin  
 Address..... 1756 Pennsylvania Ave., N.W., Wash., D.C.  
 19. 4-21 48 Mary E. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 20 April 19.. 48 at 9:36 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
14 April 19.. 48 to 20 April 19.. 48  
 and that I last saw h. im alive on 20 April 19.. 48

Immediate cause of death.....  
Pneumonia, Broncho  
 Due to.....  
 Due to.....  
 Other conditions..... Fracture Simple, c1 & c2  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results..... confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... fall down stairs at home Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... fall of back of head injured at work?  
 23. SIGNATURE..... W. R. Miller, Cdr. MC USN  
 M. D. or other  
 Address..... USNH Bethesda, Md. Date signed..... 4-21-48

RECEIVED

APR 23 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04028

216

### 1. PLACE OF DEATH:

County..... Montgomery  
City or town..... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 2 month, 4 days  
Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution?..... 2 months, 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Montgomery  
City or town..... Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 315 East Cedar Lane  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Maurice C. LATTA LATTA, Maurice Cooper

### 3. (b) Social Security Number

4. Sex..... male 5. Color or race..... W-US 6.(a) Single, married, widowed, or divorced..... widowed  
6.(b) Name of husband or wife..... Clara B. Cooper  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.)..... October 13, 1869  
8. AGE: Years..... 78 Months..... 5 Days..... 20 If less than one day..... hrs. .... min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 3 19.. 48 at 11:30AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
29 January 19.. 48 to 3 April 19.. 48  
and that I last saw him alive on 3 April 19.. 48

Immediate cause of death..... Pulmonary Thrombosis DURATION

Due to..... Enlargement Prostate

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, term, industry, public place (where?)

Means of injury..... injured at work?

23. SIGNATURE..... H. J. COKELY, Capt. MC USN M. D. or other

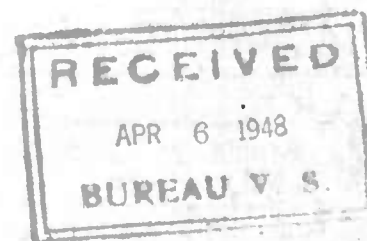
Address..... USNH Bethesda, Md. Date signed..... 4-3-48

9. Birthplace..... Penn. (Town, county, and state)  
10. Usual occupation..... Executive Clerk  
11. Industry or business..... White House  
12. Name..... LATTA, John dec.  
13. Birthplace..... Pa.  
14. Maiden name..... BAIR, Susan dec.  
15. Birthplace..... Pa.  
16. Informant..... son: Mr. James B. Latta  
Address..... 315 East Cedar Lane, Bethesda, Md.  
Burial  
17. (Burial, cremation, or removal. Which?) Date thereof..... 4-6-48 (month) (day) (year)  
Cemetery or crematory..... Rock Creek  
Location..... Washington, D.C.  
18. Funeral director..... Reuben Pumphrey P.C.D. Jr.  
Address..... Bethesda, Md.  
19. (Date rec'd by registrar) 19.. 4-3- 19.. 48 Mary C. Patterson Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04029

216

Reg. Dist. No. ....

1. PLACE OF DEATH: Montgomery  
County.....  
City or town..... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 15 hours  
Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution?..... 15 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Washington, D. C. County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 360 N St., S.W.  
(If rural, give LOCATION)  
WWI  
2. (a) if veteran, name war.....

3. (a) FULL NAME  
LEWIS, William

3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Mrs. Bonnie Lewis  
7. Birth date of deceased (mo., day, yr.) January 30, 1894 8. (c) If alive, give age..... years  
8. AGE: Years 54 Months 3 Days 0 It less than one day  
..... hrs. .... min.

9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name LEWIS, William dec  
13. Birthplace Va.

MOTHER 14. Maiden name SISSON, Kate ded  
15. Birthplace Va.

16. Informant wife: Mrs. Bonnie Lewis  
Address 360 N St., S. W., Wash., D.C.

17. burial Date thereof 5-3-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Arlington, Va.  
Location.....

18. Funeral director W. W. CHAMBERS  
Address 517 11th St., S.W., Wash., D.C.

19. 4-30 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 30 April 19. 48 at 4:45 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
29 April 19. 48 to 30 April 19. 48  
and that I last saw him alive on 30 April 19. 48

Immediate cause of death  
Coronary Heart Disease, Arterio-  
sclerotic  
Due to Arteriosclerosis, Generalized

Due to.....

Other conditions Emphysema, Pulmonary

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury injured at work?

23. SIGNATURE L. E. Watters  
L. E. WATTERS, Jr., Lt. JG MC USN  
M. D. or other

Address USNH Bethesda, Md. Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 5 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04030

216

## 1. PLACE OF DEATH:

County Montgomery Co.City or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4-6-48 at 9 PM - 4-7-48 5:30 AMHospital, institution, or street address where death occurred Suburban Hosp, 8600 Old Georgetown Rd Bethesda MdHow long in hospital or institution? 4-6-48 at 9 PM - 4-7-48 5 AM

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington D.C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1327-16th St.  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Mr Harry G. Hinder

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Louise Hinder (Dec.)

## 7. Birth date of

deceased (mo., day, yr.)

Feb. 15, 1880

## 6. (c) If alive, give age

## 8. AGE:

Years

Months

Days

If less than one day

68122

hrs.

min.

9. Birthplace Lincoln Nebraska

(Town, county, and state)

10. Usual occupation Clerk -> Internal Revenue

## 11. Industry or business

## MOTHER

## FATHER

12. Name Henry Hinder13. Birthplace Brooklyn N.Y.14. Maiden name Chrissie Cumming15. Birthplace Isle of Man - England

## 16. Informant

Address

17. BURIAL  
(Burial, cremation, or removal. Which?)Date thereof 10 APR, 1948  
(month) (day) (year)Cemetery or crematory FORT LINCOLN CEMETERYLocation PRINCE GEORGES CO., MD.18. Funeral director Martin W. Nyeong Co.Address 1300 "N" St. N.W. Wash. D.C.19. 4-9-48  
(Date rec'd by registrar)W.E. Cobb

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

4-719 48 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 18 47 to April 7 48and that I last saw him alive on 7 April 1948Immediate cause of death Comp. Int. Heart Failure DURATIONPneumonia - lobar - pneumococcal 1 weekDue to Cerebral Artery Phlebitis (5-6-48/ams.)

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

None

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles T. Halley MD915-19 NW Wash DC Date signed April 48

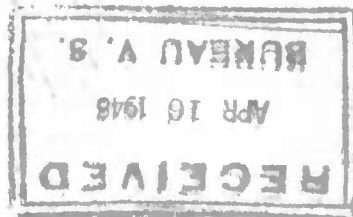
MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Authorization for change on the cause of death received from Dr. Halley who reported that the autopsy disclosed the proper cause of death. 5-6-48 . ams





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04031

216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

48

N.E. Joe

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 5, 1948 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 31, 1948, to April 5, 1948

and that I last saw him alive on

Apr. 5, 1948

Immediate cause of death

Atherosclerosis  
Prematurity

DURATION

Due to

Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Isacovic

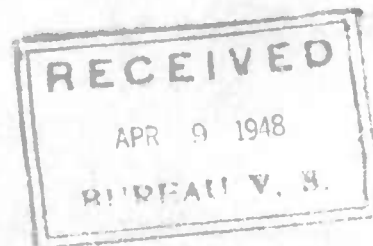
M. D. or other

Address

848 Ba Ave  
Silver Spring, Md.

Date signed

Apr. 6, 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age and birth date shown on: is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age and birth date shown on:  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 4211 N. Charles St., Baltimore 123  
**CERTIFICATE OF DEATH**

04032

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 8 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?..... 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D.C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1417 Newton St., N.W.  
 (If rural, give LOCATION)  
WWI  
 2.(a) If veteran, name war.....

## 3.(a) FULL NAME

LOMAX, Morin

## 3.(b) Social Security Number

4. Sex..... male 5. Color or race..... Col 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Maude Lomax  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... March 29, 1887 1897  
 8. AGE: Years..... 51 Months..... 0 Days..... 17 If less than one day..... hrs. .... min.

9. Birthplace..... Maryland  
 (Town, county, and state)  
 10. Usual occupation..... Janitor  
 11. Industry or business.....  
 12. Name..... LOMAX, Henry dec.  
 13. Birthplace..... Va.  
 14. Maiden name..... THOMAS, Henretta dec.  
 15. Birthplace..... Md.

16. Informant..... wife: Mrs. Maude Lomax  
 Address..... 1417 Newton St., N. W., Wash., D.C.  
 17. burial Date thereof..... Apr. 20, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National  
 Location..... Arlington, Va.

18. Funeral director..... Johnson & Jenkins Funeral Home  
 Address..... 2053 Georgia Ave. Washington, D. C.  
 19. 4-17 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 16 April 19 48 at 1:55 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
8 April 19 48 to 16 April 19 48  
 and that I last saw him alive on 16 April 19 48

Immediate cause of death.....  
Poisoning, Therapeutic, Acute DURATION 20 Min.  
(1% Procaine in Sacrocaudal block  
 Due to..... anesthesia manifestation circulatory  
and respiratory collapse).  
 Due to..... Anesthesia being administered for  
operation for fissure in ano.  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Fissure in ano.  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Acc. Date of 4/-/48  
 Where did injury occur?..... (In Hospital) Mont Co. Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... T.W. Stewart Injured at work?  
 23. SIGNATURE..... T. W. Stewart LTJG MC USN  
 M. D. or other  
 Address..... USNH Bethesda, Md. Date signed..... 4-17-48

RECEIVED  
APR 20 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 714

### 1. PLACE OF DEATH

County Montgomery

City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Montgomery

City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2115 Cascade Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

Peter Maguire

### 3.(b) Social Security Number

092-10-2689

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife CATHERINE F. MAGUIRE

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.)

Oct 31 1882

8. AGE:

Years

65

Months

5

Days

1

If less than one day

hrs.

min.

9. Birthplace ENNISKILLEN FERMANAGH, Ireland  
(Town, county, and state)

10. Usual occupation Restaurant

11. Industry or business

FATHER

12. Name Peter Maguire

13. Birthplace ENNISKILLEN FERMANAGH, Ireland

MOTHER

14. Maiden name Catherine Rock

15. Birthplace Kingston N.Y.

16. Informant Peter P. Maguire

Address 2115 Cascade Rd Silver Spring MD

17. Burial  
(Burial, cremation, or removal) Which?

Date thereof April 5 1948  
(month) (day) (year)

Cemetery or crematory Holy Cross

Location Brooklyn, New York

18. Funeral director

Walter E. Humphrey

Address 8434 La. Ave Silver Spring Md

19. Apr 2  
(Date rec'd by registrar)

Joseph E. Schwartz  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2 April 1948 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1947, to 2 April 1948  
and that I last saw him alive on 31 March 1948

Immediate cause of death

Coronary Decompensation

DURATION

4-5 days

Due to Hypertension  
Atherosclerosis

?

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William D. And MD

M. D. or other

Address Silver Spring Md Date signed 2 April 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 6 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04034 213

### 1. PLACE OF DEATH:

County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Months

Hospital, institution, or street address where death occurred:

520 Anderson Ave., - Home

How long in hospital or institution? Home - 3 Months

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 520 Anderson Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war No

### 3. (a) FULL NAME

MABEL ELEAN MARKLEY

### 3. (b) Social Security Number

None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Jonah A. Markley

7. Birth date of deceased (mo., day, yr.) July 11, 1867

6. (c) If alive, give age Dec. years

8. AGE: Years 80 Months 8 Days 20 It less than one day

hrs. min.

9. Birthplace Unknown Pennsylvania

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Unknown Montague

13. Birthplace France

14. Maiden name Eleanor Ellsworth

15. Birthplace England

16. Informant Helen M. Moulden

Address 520 Anderson Ave., Rockville, Md.

17. Burial Date thereof April 3, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Washington, D. C.

18. Funeral director Wm. R. Ransom

Address Bethesda 14, Maryland

19. April 3 1948 E. Thompson

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948 at 7:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JANUARY 2 1948 to March 31 1948

and that I last saw him alive on MARCH 31 1948

Immediate cause of death

Coronary Thrombosis

with Congestive Heart Failure

Due to Hypertensive

Arterio-sclerotic Heart Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gordon S. Rasmussen, M.D.

Address Rockville, Maryland Date signed 4/11/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 7 1948

BUREAU V. B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery

City or town Be the sda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Suburban Hosp. 8600 Georgetown Rd.

How long in hospital or institution? 18 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. of Col. County

City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3525 Davenport St. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war ☒

### 3. (a) FULL NAME

Mrs. Marian E. Martin

### 3. (b) Social Security Number

#### 4. Sex

Female

#### 5. Color or race

White

#### 6.(c) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Wesley R. Martin

7. Birth date of deceased (mo., day, yr.) July 27, 1877

6.(c) If alive, give age years

8. AGE: Years 70 Months 8 Days 7 If less than one day hrs. min.

9. Birthplace Olney, Maryland  
(Town, county, and state)

10. Usual occupation Housewife

#### 11. Industry or business

12. Name Josiah Jones

13. Birthplace Montgomery Co. Maryland

14. Maiden name Marj Barnsley

15. Birthplace Montgomery Co., Maryland

16. Informant

Address

17. Burial Date thereof Apr. 6, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery St. Johns Episcopal Church

Location St. Johns Co. Olney, Md.

18. Funeral director

Address

2901-14th St NW

19. 4/4 19 48 Wm E Jones

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 19 48 at 12:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 19 47 to April 4 19 48 and that I last saw him alive on April 2 19 48.

Immediate cause of death Cerebral hemorrhage DURATION 18 days

Due to Generalized Arteriosclerosis and hypertension Many years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

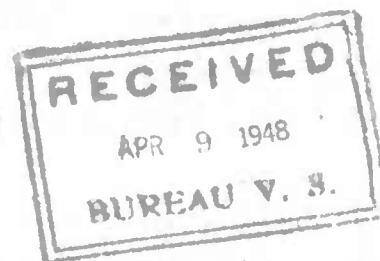
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard J. Mattingly M.D. M. D. or other

Address 4707 Conn. Ave. Wash. D.C. Date signed 4/4/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 108  
CERTIFICATE OF DEATH

04036

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4402 Jones Bridge Rd.  
(If rural, give LOCATION)

2(a) If veteran, name war:

## 3. (a) FULL NAME

MRS. FANNIE LEE MAYNARD

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Edw. Maynard

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

Sept. 20, 1865

8. AGE:

Years

Months

Days

If less than one day

82614

hrs.

min.

9. Birthplace

June Co. Va.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

12. Name

Thomas Andrews

13. Birthplace

June Co. Va.

14. Maiden name

Frances Duell

15. Birthplace

June Co. Va.

16. Informant

Sara Frances Maynard

Address

1660 Lanier Pl. NW, D.C.

17. Burial

Pr. Lincoln

Cemetery or crematory

Location

Prince George's, Md.

18. Funeral director

A. H. Thomas Co.

Address

2901 14th St. NW, Washington, D.C.19. Apr 3 19 48

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10, 1948 to April 3, 1948and that I last saw him/her alive on April 3, 1948

Immediate cause of death

Infarction - Labor

Due to

Chronic Interference

Due to

Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. W. J. Key

Address

541 Maple Ridge Rd. Bethesda, Md.Date signed 4-3-48

**RECEIVED**

APR 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalsHow long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia CountyCity or town Washington D.C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1909 19th St. N.W. Apt. 202  
(If rural, give LOCATION)2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

MR. WALTER A. McCormick

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife Maude M. McCormick7. Birth date of deceased (mo., day, yr.) November 13, 1913

6. (c) If alive, give age..... years

8. AGE: Years 64 Months 5 Days 10 If less than one day  
.....hrs. ....min.9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation Painter

## 11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal Date thereof April 23 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.18. Funeral director J. Williams Lee & Sons Co.Address 360 - 4th St. N.E. Wash. D.C.19. April 23 1948  
(Date received by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 19 48, at 11:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
1-19- 19 48, to 4-23- 19 48  
and that I last saw him alive on 4-23- 19 48Immediate cause of death Acute Coronary Occlusion

## DURATION

Due to Arteriosclerosis years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

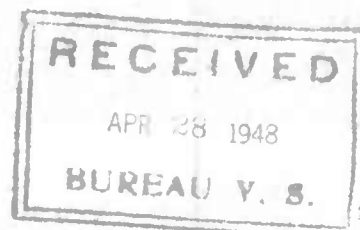
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Ashare M.D. M. D. or otherAddress Takoma Park, Md. Date signed 4/23/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3601 Livingston St., N.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_ ✓

### 3. (a) FULL NAME

MENERATTI, Lucille Westover

### 3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Herbert J. Meneratti  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) November 23, 1887  
8. AGE: Years 60 Months 4 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ohio  
(Town, county, and state)  
10. Usual occupation housewife  
11. Industry or business \_\_\_\_\_  
FATHER 12. Name WESTOVER, Henry J.  
13. Birthplace England  
MOTHER 14. Maiden name EGGLEFIELD, Martha  
15. Birthplace Canada

16. Informant husband: Mr. Herbert J. Meneratti  
Address 3601 Livingston St., N.W., Wash., D.C.

17. burial Date thereof \_\_\_\_\_ (month) (day) (year)  
(Burial, cremation, or removal, Which?)  
Cemetery or crematory Arlington National  
Location Arlington, Va.

18. Funeral director W. W. CHAMBERS  
Address 1100 Chapin St., N.W. Wash., D.C.

19. 4-12 19 48 Mary E. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 19 48 at 10:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 April 19 48 to 11 April 19 48  
and that I last saw h. or alive on 11 April 19 48

Immediate cause of death Acute infarct hemorrhage  
Reparative pneumonia  
Hyper-tensive Cardiovascular  
renal disease.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

MAJOR FINDINGS OF OPERATIONS \_\_\_\_\_  
Date of op. \_\_\_\_\_  
Autopsy results Same as above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
J. T. Fowler Jr.  
J. T. FOWLER, Cdr. MC USN

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_  
Address USNH Bethesda, Md. Date signed 4-12-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1948

BUREAU V. S.







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital, Inc.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Woodbine  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Lisbon  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Betty Molesworth

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Charles Molesworth

7. Birth date of deceased (mo., day, yr.)

August 25, 1892

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

75722

hrs.

min.

9. Birthplace

Florence, Howard Co. Maryland  
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home

FATHER

12. Name

Mr. George Gillis

13. Birthplace

Carroll County, Md.

MOTHER

14. Maiden name

Miss Rachel Pettit

15. Birthplace

Howard Co., Md.

16. Informant

Hospital record

Address

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

4-30-48  
(month) (day) (year)

Cemetery or crematory

Poplar Springs

Location

Poplar Springs, Howard Co. Md.

18. Funeral director

C. M. Wicks

Address

Winfield, Md.

19.

4-17

19

48Bertine B. Lawler

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 at 9:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 April1948to April 171948and that I last saw her alive on April 17 1948

Immediate cause of death

Coronary HeartFailure

DURATION

7 weeks

Due to

Hypertensive Cardiovascular diseaseUndetected

Due to

1) Arteriosclerosis, mildArteriosclerosis

Other conditions

2) Arteriosclerosis, generalized

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

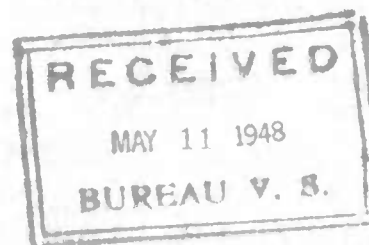
23. SIGNATURE

Jack Schumacher M.D.

M. D. or other

Address

Ledy Tinsville Md.Date signed 17 Apr 48



Address Danvers, Ind M. D. or other + Date signed 4-3-48

VS A15-9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

APR 6 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04042 211

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rural Bethesda Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Cornie B. Mullican

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife George Mullican  
 7. Birth date of deceased (mo., day, yr.) Aug 31 - 1843 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 82 Months 10 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Md  
(Town, county, and state)10. Usual occupation none11. Industry or business noneFATHER 12. Name Ralph Turner13. Birthplace MdMOTHER 14. Maiden name Mattie Watkins15. Birthplace Md16. Informant Dr. Clarence D. G.Address Clarksburg Md17. Burial Burial Date thereof April 24-1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Bethesda MdLocation Broomfield Md18. Funeral director W. BarberAddress Rockville Md19. Date rec'd by registrar Feb 23 48 Registrar Della K. Boudette

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1948, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 16, 1947, to April 21, 1948and that I last saw ER alive on April 2, 1948Immediate cause of death Arteriosclerotic cardiovascular disease DURATION 23 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE James P. Kerr M.D. M. D. or otherAddress Baltimore, Md. Date signed 4/23/48

RECEIVED  
APR 29 1948  
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Montgomery  
 County Bethesda (rural)  
 City or town 29 days  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 29 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Md. County R. Co.  
 City or town Brentwood  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4004 38th Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war U.S. Marine Corps ✓

3. (a) FULL NAME  
MULLICAN, Owen

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife .....  
 6. (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) 18 May 1864  
 8. AGE: Years 83 Months 10 Days 29 If less than one day ..... hrs. .... min.

9. Birthplace Ireland  
 (Town, county, and state)  
 10. Usual occupation Retired Marine Corps  
 11. Industry or business .....  
 FATHER 12. Name MULLICAN, James dec. ....  
 13. Birthplace Ireland  
 MOTHER 14. Maiden name GOULDING, Ellen dec. ....  
 15. Birthplace Ireland

16. Informant daughter: Mrs. Susan E. Gunn  
 Address Churchton, Md.  
 17. burial Date thereof 4-21-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Virginia  
 18. Funeral director Gasch's Sons Jan 13  
 Address Hyattsville, Maryland  
 19. 1-19 18 18 18  
 (Date rec'd by registrar) Registrar Mary C. Patterson  
Mary C. Patterson

## MEDICAL CERTIFICATION

20. DATE OF DEATH 17 April 19 48 at 4 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 March 19 48 to 17 April 19 48  
 and that I last saw him alive on 17 April 19 48

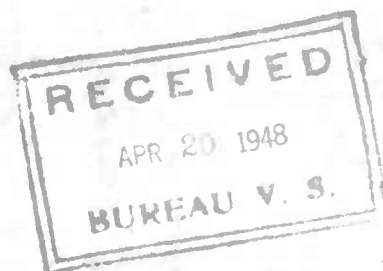
Immediate cause of death Pulmonary Embolism DURATION Min.  
 Due to Thrombosis femoral Days .....  
 Due to .....  
 Other conditions Carcinoma of sigmoid Mors .....  
 (Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....

Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? ..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury Janusphy Injured at work?

23. SIGNATURE J. A. MURPHY, Cdr. MC USN M. D. or other  
 Address USNH Bethesda, Md. Date signed 4-19-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160c

04044

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery  
 City or town Montg Kensington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4101 Warner Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Dale Anthony Nardini

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced MARRIED  
 6. (b) Name of husband or wife  
 7. Birth date at deceased (mo., day, yr.) April 17, 1948 8. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name NARDINI, John Edward13. Birthplace Penna.14. Maternal name PREVAIL, Helen Dorothy15. Birthplace Penna.16. Informant father: Dr. John E. NardiniAddress 4101 Warner St., Kensington, Md.

17. burial Date thereof 4-21-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Virginia18. Funeral director W. W. CHAMBERSAddress Georgetown, D. C.

19. 4-20 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 20 April 19 48 at 5:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
17 April 19 48 to 20 April 19 48

and that I last saw him alive on 20 April 19 48

Immediate cause of death Premature rupture of membranes DURATION

Due to Premature rupture of membranes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

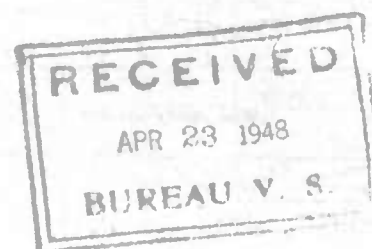
Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE PAUL PETERSON, Capt. MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 4-20-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County Montgomery Co  
 City or town Faithsburg Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 1/2 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Montgomery  
 City or town Faithsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George Arthur

## 3. (b) Social Security Number

XXXX-XX-XXXX4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorcedMarried

## 6.(b) Name of husband or wife

Hattie S. Minas6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.)

Oct 30 1878

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>5</u>	<u>7</u>	hrs. min.

9. Birthplace

Columbia, Mo  
(Town, county, and state)

10. Usual occupation

Retired Accountant

11. Industry or business

12. Name 50 Frederick Minas

13. Birthplace

Perrin

14. Maiden name

M. Minas

15. Birthplace

Mo

16. Informant

Georgeta Minas Jr.

Address

109 Allen Rd. Wash, 16

17. Burial

(Burial, cremation, or removal)

Date thereof

4/9/48  
(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Armed Forces Cemetery

18. Funeral director

Joseph B. Parker

Address

Faithsburg Md

19. (Date rec'd by registrar)

April 8 48 Alveda L. Cooke  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 7 1948 10:33 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep Md Exam Case 19 to 19  
 and that I last saw h. alive on 19

Immediate cause of death

Crushed skull with multiple fractures of  
skull and body

Due to

Struck by train  
(suicide)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of 4-7-48

Where did injury occur?

Faithsburg Md  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

B&O R.R.

Means of injury

Jumped in front of train  
Frank J. Bushart Md

23. SIGNATURE

Dep Md Exam M. D. or other

Address

Faithsburg Md Date signed 4-8-48

## CAUSE OF DEATH

Crushed skull with multiple fractures of skull and body  
Struck by train (suicide)

RECEIVED

APR 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 Years

Hospital, institution, or street address where death occurred:

Home - 4916 Hampden Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4916 Hampden Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3.(a) FULL NAME

NORVAL LEE NUTWELL

## 3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Daisy Held Nutwell6.(c) If alive, give age Dec. years7. Birth date of deceased (mo., day, yr.) June 17, 1863

8. AGE:

Years

Months

Days

If less than one day

8484101

hrs.

min.

9. Birthplace Hughesville, Charles Co., Md.  
(Town, county, and state)10. Usual occupation Retired11. Industry or business Feed Business12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown Moran15. Birthplace Unknown16. Informant Mrs. Evelyn N. RaymerAddress 4916 Hampden Lane, Bethesda, Md.17. Burial Date thereof Apr. 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Glenwood CemeteryLocation Washington, D. C.18. Funeral director Wm. Roush PumphreyAddress Bethesda, Maryland19. 4/20 19 48 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18th, 19 48, at 11:50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 40 to April 18 19 48  
and that I last saw him alive on April 18 19 48

Immediate cause of death

Coronary Occlusion

DURATION

1 hr

Due to

Arterio-sclerotic heart disease6 year

Due to

Other conditions

Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bruce T. Benjamin M.D.  
Bethesda, Md.

M. D. or other

Date signed 4/19/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

159

04047

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery  
 County.....  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 4 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?..... 3 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... D.C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 710 8th St., N.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ☒

## 3.(a) FULL NAME

PAINE, John Wendell

## 3.(b) Social Security Number

4. Sex..... male  
 5. Color or race..... W-US  
 6.(a) Single, married, widowed, or divorced..... single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... April 12, 1948  
 8. AGE: Years..... Months..... Days..... If less than one day.....  
1..... 16..... hrs. .... min.

9. Birthplace..... Bethesda, Maryland  
 (Town, county, and state)  
 10. Usual occupation.....  
 11. Industry or business.....  
 12. Name..... PAINE, Wendell E.  
 13. Birthplace..... Maine  
 14. Maiden name..... CRADIER, Jean  
 15. Birthplace..... Pa.

16. Informant..... husband: Mr. Wendell E. Paine  
 Address..... 710 8th St., N.E., Wash., D.C.  
 17. burial  
 (Burial, cremation, or removal, Which?) Date thereof..... 4-15-48  
 (month) (day) (year)  
 Cemetery or crematory..... Arlington National  
 Location..... Arlington, Va.

18. Funeral director..... W. W. CHAMBERS  
 Address..... Georgetown, D.C.  
 19. 4-13..... 19 48..... Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 13 April 19 48 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
12 April 19 48 to 13 April 19 48  
 and that I last saw him alive on 13 April 19 48

Immediate cause of death..... atelectasis, both lungs -  
Pneumonia - 8 months  
 DURATION..... 24 hrs.

Due to.....  
 Due to.....

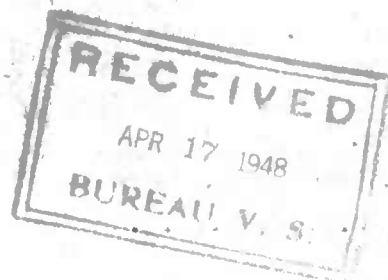
Other conditions..... none  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results..... Confirmed the above -  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... PAUL PETERSON, Capt. MC USN  
 M. D. or other  
 Address..... USNH Bethesda, Md. Date signed..... 4-13-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04048

276

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 days  
Hospital, institution, or street address where death occurred:  
Baptist Home for Children  
How long in hospital or institution? 15 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6201 Greenview Rd  
(If rural, give LOCATION)  
2.(a) If veteran, name war (8.5-4.14.7.6.2C)

### 3. (a) FULL NAME

Lois Carol Pratt

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 14 1942 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 6 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington D C  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Lehman Pratt  
13. Birthplace ?  
14. Maiden name Mary Carter  
15. Birthplace ?

16. Informant Mother  
Address 815-4th St. N.W.

17. (Burial, cremation, or removal, Which?) Burial Date thereof 4/16/48  
(month) (day) (year)

Cemetery or crematory Family Bur. Co.  
Leewood Co N.R.  
Location The S. H. Hines Co

18. Funeral director The S. H. Hines Co  
Address 2901-14th St. N.W.

19. 4/15 19 48 W E Jones Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 48 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 12 19 48 to Apr 15 19 48

and that I last saw him/her alive on Apr 15 19 48

Immediate cause of death Encephalitis  
questionable

Due to Measles - Viral infection

Due to

Other conditions Healed Primary  
Subcutaneous  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results showed extensive hemorrhagic pneumonia  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

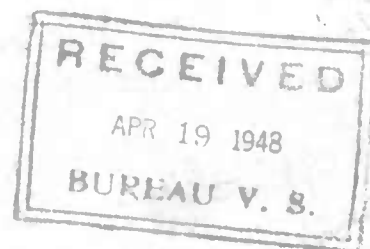
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W E Jones M.D. or other  
Address Cherry Lane Md Date signed Apr 15 '48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04049

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 YearsHospital, institution, or street address where death occurred:  
Home - 4807 Hampden Lane, Bethesda, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4807 Hampden Lane  
(If rural, give LOCATION)2.(a) If veteran, name war No

## 3. (a) FULL NAME

F. IRWIN RAY

## 3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Divorced</u>

6. (b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) April 4, 1890

8. AGE:	Years	Months	Days	If less than one day
<u>58</u>	<u>58</u>	<u>0</u>	<u>26</u>	<u>3</u> hrs. <u>min.</u>

9. Birthplace Montgomery Co., Maryland  
(Town, county, and state)10. Usual occupation Contractor

11. Industry or business

FATHER	12. Name	<u>Richard T. Ray</u>
	13. Birthplace	<u>Maryland</u>

MOTHER	14. Maiden name	<u>Rebecca Ashell</u>
	15. Birthplace	<u>Montg. Co., Maryland</u>

16. Informant	<u>Mr. Frank Ray</u>
Address	<u>Linden, Maryland</u>

17. Burial	Date thereof	<u>May 3, 1948</u>
(Burial, cremation, or removal, Which?)	(month) (day) (year)	

Cemetery or crematory Grace Church CemeteryLocation Woodside, Maryland

18. Funeral director	<u>W. F. Rouben Pumpbrey</u>
Address	<u>Bethesda, Maryland</u>

19. <u>5/1</u>	<u>48</u>	<u>W E Jones</u>
(Date rec'd by registrar)		Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 30th, 19 48, at 6:30 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 48, to April 30 19 48 and that I last saw him alive on April 29 19 48Immediate cause of death Coronary Thrombosis  
acute

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul H. Jones M. D. or otherAddress Bethesda, Md. Date signed 7/30/48

RECEIVED

MAY 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 5 months, 20 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution?..... 5 months, 20 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md. County..... P. Lees  
 City or town..... Lanham  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Box 256  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... WWI ✓

## 3. (a) FULL NAME

ROSE, Herbert Millard

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

W-US

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

April 30, 1888

## 8. AGE:

Years

Months

Days

If less than one day

60

0

0

hrs.

min.

## 9. Birthplace

Washington, D. C.

(Town, county, and state)

## 10. Usual occupation

unemployed

## 11. Industry or business

## FATHER

## 12. Name

ROSE, George U.

dec.

## 13. Birthplace

N.Y.

## MOTHER

## 14. Maiden name

DELANOY, Emily Francis

dec.

## 15. Birthplace

N.Y.

## 16. Informant

sister: Miss Crete Rose

## Address

Lanham, Md. Box 256

## 17.

(Burial, cremation, or removal. Which?)

Date thereof.....

5-4-48

(month) (day) (year)

## Cemetery or crematory

Arlington National

## Location

Arlington, Va.

## 18. Funeral director

W. W. CHAMBERS

## Address

1400 Chapin St., N.W., Washington, D. C.

## 19.

(Date rec'd by registrar)

19

Mary C. Patterson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 30 April 19 48 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 November

19 47

to 30 April

19 48

and that I last saw him

in

alive on

30 April

19 48

Immediate cause of death

DURATION

Cause

Broncho Pneumonia

2 days

Due to

Carcinoma of rectum

Months.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

Carcinoma of rectum

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

J. A. MURPHY

23. SIGNATURE

J. A. MURPHY, Cdr. MC USN

M. D. or other

Address..... USNH Bethesda, Md.

Date signed

4-30-48

RECEIVED  
MAY 5 1948  
BUREAU V.S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04051

216

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Montgomery

County.....

City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

U. S. NAVAL HOSPITAL, Bethesda, Md.How long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County.....City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1303 Saratoga Avenue, N.E.

(If rural, give LOCATION)

WWII2. (a) If veteran, name war..... ✓

## 3. (a) FULL NAME

SAMRAS, Kharaiti

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

East

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Evelyn Samras

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) December 4, 1904

8. AGE: Years Months Days If less than one day

4347

..... hrs. .... min.

9. Birthplace Manko, India  
(Town, county, and state)10. Usual occupation Civil Service11. Industry or business State DepartmentFATHER 12. Name SAMRAS, Kura Ram13. Birthplace IndiaMOTHER 14. Maiden name ROPAL, Blashi15. Birthplace India16. Informant wife: Mrs. Evelyn SamrasAddress 1303 Saratoga Avenue, N. E., Wash., D.C.17. cremation Date thereof 4-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Washington, D.C.18. Funeral director W. W. CHAMBERS (J. B. L.)Address 1400 Chapin St., N. W., Wash., D.C.19. 4-12 48 Mary C. Patterson  
(Date rec'd by registrar) Mary C. Patterson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 19 48 at 12:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 March 19 48 to 11 April 19 48and that I last saw him alive on 11 April 19 48Immediate cause of death Hypertensivecardiovascular renal  
disease

DURATION

2 y. +

Due to.....

Due to.....

Other conditions anemia hypochromic  
marked

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

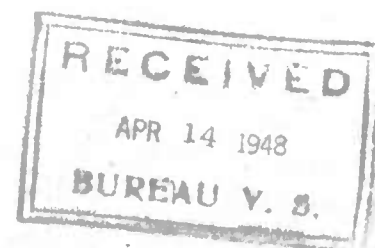
Means of injury..... Injured at work?

F. E. WETSEL23. SIGNATURE..... F. E. WETSEL, Lt. MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04052  
214

### 1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
607 Sligo Ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 607 Sligo Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

John Thomas Schrider

### 3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Clara Jane Schrider

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1870

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
77 7 13 hrs. min.

9. Birthplace Silver Spring, Md.  
(Town, county, and state)

10. Usual occupation Retired Storekeeper

### 11. Industry or business

12. Name Benjamin Franklin Schrider

13. Birthplace Hanover, Germany

14. Maiden name Susan King

15. Birthplace Maryland

16. Informant Mrs Marion C. Tyler

Address 607 Sligo Ave., Silver Spring

17. Burial Date thereof April 17, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. John's Cemetery

Location Forest Glen, Md.

18. Funeral director Waxman E. Humphrey

Address 8434 Wa. Ave., Silver Spring, Md.

19. April 16 19 48 Josephine Schaeffer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 15 April 19 48 at 2:22 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 19 48, to 15 April 19 48

and that I last saw him alive on 15 April 19 48

Immediate cause of death (Bronchial Pneumonia) Respiratory Failure

Due to Bronchial Pneumonia

Due to

Other conditions Generalized arterio-sclerosis -  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE Gordon M. Smith, M.D.

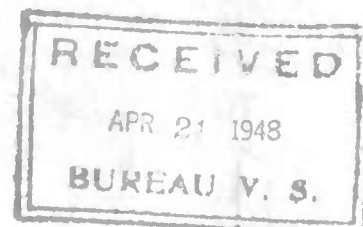
Address 1463 Rhode Island Ave N.W.D.C. Date signed 16 April 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

04053

### 1. PLACE OF DEATH:

County Montgomery  
City or town Meadowood nr. Colesville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Meadowood, nr. Colesville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Lafayette D. Seavers

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
6.(b) Name of husband or wife Mary Sophe  
7. Birth date of deceased (mo., day, yr.) July 23, 1860  
6.(c) If alive, give age years  
8. AGE: Years 87 Months 8 Days 20 If less than one day hrs. min.

9. Birthplace Virginia  
(Town, county, and state)  
10. Usual occupation Caretaker  
11. Industry or business  
12. Name unknown  
13. Birthplace unknown  
14. Maiden name unknown  
15. Birthplace unknown

16. Informant Miss Bertha Shaw  
Address 8303 Colesville Rd. Silver Spring  
17. Burial Date thereof April 15, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Glenwood Cemetery  
Location Washington, D.C.

18. Funeral director Warner E. Humphrey  
Address 8434 Ga. Ave., Silver Spring, Md.

19. Apr. 14 19 48 Josephine K. Schaeffer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 48 at 1:00 P. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19  
diag med Exam case  
and that I last saw h. alive on 19  
Immediate cause of death

Due to Coronary occlusion DURATION died suddenly  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

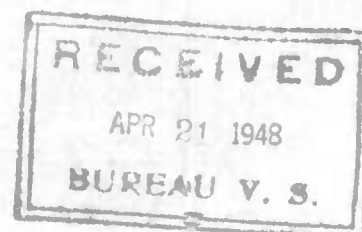
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Frank J. Brosehart M.D. M. D. or other  
diag med Exam  
Address Yairdusburg Md Date signed 4-13-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
birthdate shown on:

FILE No. G 116 MAY 25 1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0405217

### 1. PLACE OF DEATH:

County Montgomery  
City or town Road R.F.D. Rockville Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? ad in the  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Montgomery  
City or town Road R.F.D. Rockville Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION) ✓  
2(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Howard Selby

### 3. (b) Social Security Number

4

4. Sex Male 5. Color or race Cal 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) March 7 - 11/19/1947  
8. AGE: Years 1 Months 0 Days 24 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Howard Fant

13. Birthplace Md

14. Maiden name Minervia Selby

15. Birthplace Md

16. Informant Minervia Selby

Address Cokedale Md

17. Burial Date thereof April 3 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Zion Md

Location Worshipers & O Rd

18. Funeral director Ray W Barber

Address Cottonville Md

19. 4-2 19 48 Gertrude B Lawler  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 19 48 at 3:32 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 28 19 47 to April 1 19 48 and that I last saw him alive on March 31 19 48

Immediate cause of death \_\_\_\_\_ DURATION

Acute Cardiac Dilatation

Due to Chronic Myocarditis

Due to Congenital Cardiac

Other conditions Obesity

Oroncho Pneumonia 6 days

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter Sewell M.D.

Address Norbeck Md Date signed 4-2-48

RECEIVED

MAY 11 1948

BUREAU Y. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

### 1. PLACE OF DEATH:

County Montgomery  
City or town Browningville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 8 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Browningville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. —  
(If rural, give LOCATION)  
2.(a) If veteran, name war. —

### 3. (a) FULL NAME

Barry A. Shipley

### 3. (b) Social Security Number

—

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife —  
6.(c) If alive, give age — years  
7. Birth date of deceased (mo., day, yr.) April 26, 1978  
8. AGE: Years 29 Months 11 Days 20 It less than one day — hrs. — min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1948 to April 6, 1948 and that I last saw him alive on April 5, 1948

Immediate cause of death arteriosclerotic cardiovascular disease

DURATION 24 years

Due to Malnutrition

5 years

Due to Multiple vitamin deficiencies

5 years

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. Kern M.D. M. D. or other

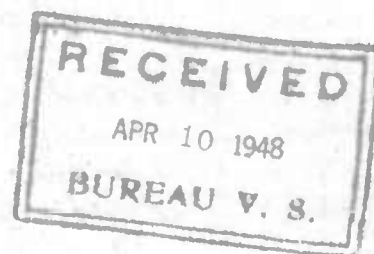
Address Wadsworth, Md. Date signed 4/7/48

9. Birthplace Maryland  
10. Usual occupation Day Laborer  
11. Industry or business —  
FATHER 12. Name John Robert Shipley  
13. Birthplace Maryland  
MOTHER 14. Maiden name Mary A. Snowden  
15. Birthplace Maryland  
16. Informant Anthony Smith  
Address nonrovia maryland  
17. Burial Burial Date thereof April 8, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Bethesda and lawn  
Location Browningville Md.  
18. Funeral director J. B. Beall, Inc.  
Address Wadsworth, Md.  
19. April 8, 1948 Della W. Burdett  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A151 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: **Montgomery**  
 County.....  
 City or town..... **Bethesda (rural)**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **20** days  
 Hospital, institution, or street address where death occurred:  
**U. S. NAVAL HOSPITAL, Bethesda, Md.**  
 How long in hospital or institution? **20** days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... **Virginia** County.....  
 City or town..... **Vienna**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **Box 7, Route 4**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war. **SP. AM.** ✓

3. (a) FULL NAME

SIMMONS, Oliver George

3. (b) Social Security Number

4. Sex **male** 5. Color or race **W-US** 6.(a) Single, married, widowed, or divorced **married**  
 6.(b) Name of husband or wife **Dual Simmons**  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) **July 14, 1877**  
 8. AGE: Years Months Days If less than one day  
**70 8 25** ..... hrs. .... min.

9. Birthplace **Penna.**  
 (Town, county, and state)  
 10. Usual occupation **President National Tools Co.**  
 11. Industry or business **Cleveland, Ohio (retired)**  
 FATHER 12. Name **SIMMONS, George**  
 13. Birthplace **Scotland**  
 MOTHER 14. Maiden name **ELDER, Genny**  
 15. Birthplace **Ireland**

16. Informant **wife: Mrs. Dual Simmons**  
 Address **Rt. #4, Box 7, Vienna, Va.**  
 17. **burial** Date thereof **4-13-48**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory **Arlington National**  
 Location **Arlington, Virginia**  
 18. Funeral director **S. H. HINES** **awm**  
 Address **2901 14th St., N. W., Wash., D.C.**  
 19. **4-9-48** 19 **48** **Mary S. Patterson** Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **9 April** 19 **48** at **9:20A** M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**19 March** 19 **48** to **9 April** 19 **48**  
 and that I last saw him alive on **9 April** 19 **48**

Immediate cause of death..... **Broncho pneumonia** DURATION **2 wks.**

Due to **Coronary heart Disease**  
**arterio-sclerotic.**

Due to.....  
 Other conditions.....  
 (Include pregnancy within 8 months of death)

Major findings of operations.....  
 Autopsy results..... **not obtained** Date of op.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury **J.E. Wetzel** Injured at work?

23. SIGNATURE..... **F. E. WETZEL, Lt. MC USN** M. D. or other  
 Address **USNH Bethesda, Md.** Date signed **4-9-48**

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04657  
218

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 9 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?..... 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D.C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 5301 Central Avenue, S.E.,  
 (If rural, give LOCATION)  
Sp. Am. ✓  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

SMITH, Charles Henry

## 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... Col. 6. (a) Single, married, widowed, or divorced..... married  
 6. (b) Name of husband or wife..... Ann F. Smith  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... December 9, 1877  
 8. AGE: Years..... 70 Months..... 3 Days..... 24 It less than one day..... hrs. .... min.

9. Birthplace..... N.C.  
 (Town, county, and state)  
 10. Usual occupation..... Minister  
 11. Industry or business.....  
 12. Name..... SMITH, Turner dec.  
 13. Birthplace..... N.C.  
 14. Maiden name..... BAKER, Chainny dec.  
 15. Birthplace..... N.C.

16. Informant..... wife: Mrs. Ann F. Smith  
 Address..... 5301 Central Avenue, S.E., Wash., D.C.  
 17. burial Date thereof..... 4-7-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Lincoln Memorial  
 Location..... Suitland, Md.  
 18. Funeral director..... W. Ernest Jarvis L.H.  
 Address..... 1432 U St., N. W., Wash., D.C.  
Mary C. Patterson  
 19. 4-4- 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 3 April 19... 48 .. at 2:20 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
26 March 19... 48 .. to 3 April 19... 48 ..  
 and that I last saw him alive on 3 April 19... 48 ..

Immediate cause of death.....  
Carcinoma of Pancreas  
 Due to..... Malnutrition  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)  
 Major findings of operations.....  
 Date of op.....  
 Autopsy results..... Confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... R. L. Fleck Injured at work?  
 23. SIGNATURE..... R. L. FLECK, Lt. MC USN  
 M. D. or other  
 Address..... USNH Bethesda, Md. Date signed..... 4-4-48

RECEIVED

APR 6 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 04058 216

### 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 16 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution?..... 16 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D.C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 1104 12th St., N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... WWI ✓

### 3. (a) FULL NAME

SMITH, Frank Rufus

### 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... W-US 6. (a) Single, married, widowed, or divorced..... single  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... July 3, 1898  
 8. AGE: Years..... 49 Months..... 9 Days..... 23 If less than one day..... hrs. .... min.

9. Birthplace..... Georgia  
 (Town, county, and state)  
 10. Usual occupation..... Civil Service  
 11. Industry or business.....

FATHER 12. Name..... SMITH, Frank dec.....  
 13. Birthplace..... Tenn.

MOTHER 14. Maiden name..... THOMPSON, Claudia dec.....  
 15. Birthplace..... Georgia

16. Informant..... brother: Mr. Joseph J. Smith  
 Address..... 309 Calvin Road, Raleigh, N.C.

17. burial Date thereof..... (month) (day) (year)  
 (Burial, cremation, or removal. Which?)  
 Cemetery or crematory..... Presbyterian Cemetery  
 Location..... Lexington, Ga.

18. Funeral director..... W. W. CHAMBERS  
 Address..... 1400 Chapin St., N. W., Wash., D.C.  
Mary C. Patterson

19. 4-27 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... 26 April 19 48, at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
10 April 19 48, to 26 April 19 48.  
 and that I last saw him alive on 26 April 19 48.

Immediate cause of death..... DURATION  
Valvular Heart Disease (Aortic Insufficiency) Indef.  
 Due to..... Syphilis Indef.  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results..... confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

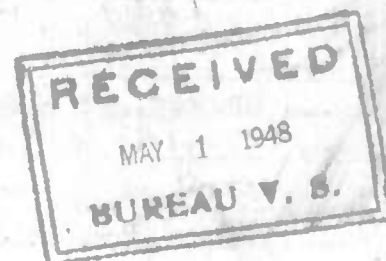
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... L. E. Watters Injured at work?  
L. E. WATTERS, Jr., Lt. JG MC USN  
 23. SIGNATURE..... M. D. or other  
USNH Bethesda, Md. 4-27-48  
 Address..... Date signed.....

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04059 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: Crestwood Lodge San.  
Slay in hospital or inst. (yrs., or mos., or days) 1 wk. 5 days  
Slay in this community (yrs., or mos., or days) 2 wks

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Bethesda Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 4815 Battery Lane  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR No

### 3. (a) FULL NAME

**STANTON, EDMUND C.**

### 3. (b) Social Security Number

None

4. Sex M. 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Sina M. Stanton

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) September 17, 1877

8. AGE: Years 70 Months 70 Days 6 If less than one day 21 hrs. \_\_\_\_\_ min.

9. Birthplace Barnesville, Ohio  
(Town, county, and state)

10. Usual occupation Electrical Engineer-Retired

### 11. Industry or business

FATHER 12. Name Daniel E. Stanton  
13. Birthplace Barnesville, Ohio

MOTHER 14. Maiden name Rebecca D. Bundy  
15. Birthplace Barnesville, Ohio

16. Informant Sina M. Stanton  
Address 4815 Battery Lane, Bethesda, Md.

17. Cremation Date thereof April 12, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Cedar Hill Crematory  
Location Washington, D. C.

18. Funeral director Wm. Rauden Pumphrey  
Address Bethesda, Maryland

19. April 10 19 48 RE Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 19 48, at 12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 \_\_\_\_\_ to 19 \_\_\_\_\_  
and that I last saw him alive on 8 April 19 48

Immediate cause of death Hypertensive encephalopathy

### DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) (Stanley H. Cleland)  
Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

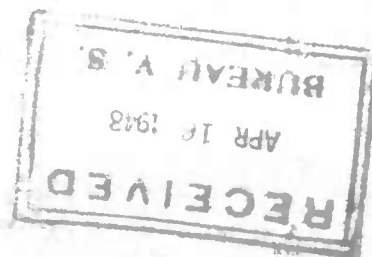
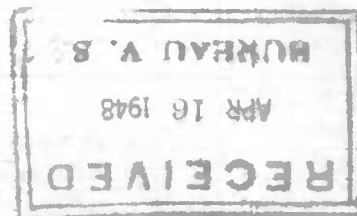
23. SIGNATURE Stanley H. Cleland M.D.

Address Crestwood Lodge San. Date signed 8 April

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04660 216

### 1. PLACE OF DEATH:

County Montgomery County  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 Weeks  
Hospital, institution, or street address where death occurred:  
4923 Battery Lane - (Home)  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4923 Battery Lane  
(If rural, give LOCATION)  
2. (a) If veteran, name war No

### 3. (a) FULL NAME

CHARLES TAYLOR

### 3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
6. (b) Name of husband or wife <u>Nancy Taylor</u>		
6. (c) If alive, give age <u>Dec.</u> years		
7. Birth date of deceased (mo., day, yr.) <u>July 14, 1861</u>		
8. AGE: Years <u>86</u>	Months <u>86</u>	Days <u>8</u>
If less than one day ..... hrs. .... min.		

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th, 19 48 at 9:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 19 48 to April 5 19 48  
and that I last saw him alive on April 5 19 48  
Immediate cause of death Coronary thrombosis DURATION

Due to Coronary heart disease  
Due to  
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Joseph P. Hennrich M. D. or other  
Address 7942 W isconsin Ave, Bethesda, Md. Date signed 4/6/48

9. Birthplace Unknown New York  
(Town, county, and state)  
10. Usual occupation Retired  
11. Industry or business  
12. Name Edward Taylor  
13. Birthplace New York  
14. Maiden name Fanny Holt  
15. Birthplace New York  
16. Informant Lauriston Taylor  
Address 4923 Battery Lane, Bethesda, Md.  
17. Cremation Date thereof April 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Cedar Hill Cemetery  
Location Prince George County, Maryland  
18. Funeral director W. R. Thompson  
Address Bethesda 14, Maryland  
19. 4/6/48 19 48 W. R. Thompson  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 13 1948

BUREAU V. 4.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 108

04061

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 12 1/2 hours  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?..... 12 1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Va. County.....  
 City or town..... Alexandria  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 514 King Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... WWII

## 3. (a) FULL NAME

TAYLOR, George Martin

## 3. (b) Social Security Number

4. Sex..... male 5. Color or race..... W-US 6. (a) Single, married, widowed, or divorced..... divorced  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... December 15, 1906  
 8. AGE: Years..... 41 Months..... 4 Days..... 0 If less than one day..... hrs. .... min.

9. Birthplace..... Virginia  
 (Town, county, and state)  
 10. Usual occupation..... Meatcutter  
 11. Industry or business.....  
 12. Name..... TAYLOR, Edward L. dec  
 13. Birthplace..... Va.  
 14. Maiden name..... CRISMOND, Minnie dec  
 15. Birthplace..... Va.

16. Informant..... brother: Mr. Everett L. Taylor  
 Address..... 514 King St., Alexandria, Va.  
 17. burial Date thereof..... 4-19-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National  
 Location..... Arlington, Va.  
 18. Funeral director..... W. W. Chambers, JBB  
 Address..... Georgetown, D. C.  
Mary C. Patterson  
Mary C. Patterson  
 19. 4-16 48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

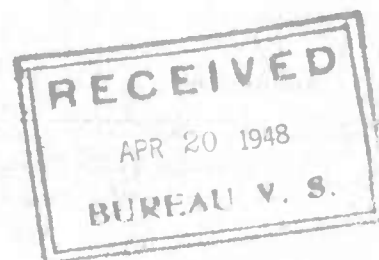
20. DATE OF DEATH..... 16 April 19.. 48 at 8:50 A.M.  
 21. I CERTIFY that death occurred on the date above stated: ~~that death occurred on~~  
15 April 19.. 48 to 16 April 19.. 48

and that I last saw him..... alive on DEPUTY MEDICAL EXAMINER CASE  
 Immediate cause of death..... DURATION

Lobar pneumonia 19 hrs.  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results..... confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?  
 23. SIGNATURE..... Frank J. Broschart  
Deputy Medical Examiner M. D. or other  
 Address..... Gaithersburg, Md. Date signed 4-16-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age shown on :

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a

04062

Reg. Dist. No. 212

FILM No. G 115 MAY 19 1948

### 1. PLACE OF DEATH:

County Montgomery  
City or town Rural Boyds  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 1/2 mo  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Rural Boyds  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

NELLIE TERLEY

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female color Widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 1888 6. (c) If alive, give age years

8. AGE: Years 59 60 Months Days If less than one day  
hrs. min.

9. Birthplace Poolesville Montg Md  
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name William Jenkins

13. Birthplace Montgomery Co

14. Maiden name Annie Storied

15. Birthplace Montg Co

16. Informant Ella Palmer

Address Boys md

17. Burial Date thereof 7/22/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Martinsburg

Location near Dickerson md

18. Funeral director Clarence H Davis

Address Poolesville md

19. April 22 19 48 Montg Co  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 19 48 at 4:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 30 19 48 to April 19 19 48  
and that I last saw him alive on April 16 19 48

Immediate cause of death arteriosclerotic and vascular renal disease with terminal uremia  
Due to  
Due to  
Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

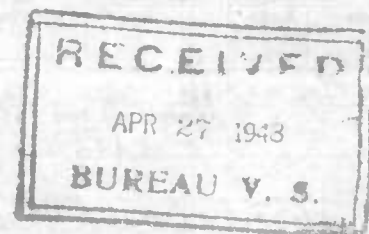
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R B McDamb MD M. D. or other

Address Poolesville md Date signed 4/21/48







# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 month, 13 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 1 month, 13 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 525 12th St., S.E., Apt. #5  
(If rural, give LOCATION)  
2.(a) If veteran, name war WWII

### 3. (a) FULL NAME

TRICE, Lawrence Ellis

### 3. (b) Social Security Number

4. Sex male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Catherine Trice  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) February 14, 1907  
8. AGE: Years 41 Months 01 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
(Town, county, and state)  
10. Usual occupation unknown  
11. Industry or business \_\_\_\_\_  
12. Name TRICE, James E. dec.  
13. Birthplace Va.  
14. Maiden name SMITH, Martha dec.  
15. Birthplace Md.

16. Informant wife: Mrs. Catherine Trice  
Address 525 12th St., S.E., Apt. #5, Wash., D.C.  
17. burial Date thereof 4-13-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Va.  
18. Funeral director W. Ernest Jarvis  
Address 1432 U St., N. W., Wash. D.C.  
19. 4-9- 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 19 48 at 10:20 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 February 19 48 to 8 April 19 48  
and that I last saw him alive on 8 April 19 48  
Immediate cause of death Bronchopneumonia and Pulmonary Edema 1 day's work  
Due to Anemia and Congestive Heart Failure Indef.  
Due to Hypertensive Cardio-Vascular and Renal Disease Indef.  
Other conditions Hypertensive retinopathy and encephalopathy  
(Include pregnancy within 9 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results Same as above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE L. E. Watters, Jr. Lt. JG MCUSN  
Address USNH Bethesda, Md. Date signed 4-9-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04064 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 years

Hospital, institution, or street address where death occurred:

15 W. Underwood Street,How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 15 W. Underwood Street,  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

Frank R. Ullmer

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Ada H. Ullmer8. (c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) February 12, 1882.

## 8. AGE:

Years

Months

Days

If less than one day

6666125

hrs.

min.

9. Birthplace Washington, D. C.  
(Town, county, and state)10. Usual occupation Retired Banker11. Industry or business None12. Name Rudolph Ullmer13. Birthplace Germany14. Maiden name Mary H. Kickman15. Birthplace Washington, D. C.16. Informant Mrs. Ross J. WoodwardAddress Chevy Chase, Maryland17. Burial (Burial, cremation, or removal. Which?) Apr. 10, 1948  
(month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation Washington, D. C.18. Funeral director Wm. Hansen Funeral HomeAddress Bethesda, Maryland19. April 10, 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1948 at 10:20 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to April 7, 1948 and that I last saw him alive on April 7, 1948

Immediate cause of death

Coronary infarction  
(thrombosis)

DURATION

14 hours

Due to

Hypertension10 years

Due to

Other conditions

(Include pregnancy within 2 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE C. Pryland M. D. or otherAddress 4901 Mass Ave NW Date signed 4-7-48  
Wash 16 DC

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
APR 16 1948  
BUREAU Y. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 month, 7 days  
Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
How long in hospital or institution? 1 month, 7 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Washington, D. C. County \_\_\_\_\_  
City or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 914 Pennsylvania Avenue, S.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

WADE, William Henderson

### 3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Charlotte M. Wade  
7. Birth date of deceased (mo., day, yr.) May 12, 1872 6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 75 Months 11 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
(Town, county, and state)  
10. Usual occupation Retired Civil Service  
11. Industry or business \_\_\_\_\_  
12. Name unknown  
13. Birthplace unknown  
14. Maiden name unknown  
15. Birthplace unknown

16. Informant wife: Mrs. Charlotte M. Wade  
Address 914 Pennsylvania Ave., S.E., Wash., D.C.  
17. burial Date thereof 5-4-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Va.

18. Funeral director W. W. CHAMBERS  
Address 517 11th St., S.E., Wash., D.C.  
4-30 48 Mary C. Patterson  
19. (Date rec'd by registrar) 18 \_\_\_\_\_ Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 30 April 19 48 at 7 A M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 March 19 48 to 30 April 19 48  
and that I last saw him alive on 30 April 19 48

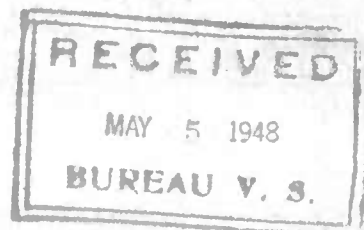
Immediate cause of death Pneumonia, Broncho DURATION Indef.  
Due to Arteriosclerosis, General Indef.  
Due to \_\_\_\_\_  
Other conditions Enlargement Prostate Indef.  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
L. E. Watters  
23. SIGNATURE L. E. WATTERS, Jr., Lt. JG MC USN  
M. D. or other \_\_\_\_\_  
Address USNH Bethesda, Md. Date signed 4-30-48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 04066  
 Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 years  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium and Hospital  
 How long in hospital or institution? 52 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 118 Carroll Avenue Takoma Park, Md.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mr. Fred Christian Wagner

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Mrs. Clara S. Wagner  
 6.(c) If alive, give age 63 years  
 7. Birth date of deceased (mo., day, yr.) Sept 5, 1883

8. AGE: Years 64 Months 7 Days 4 If less than one day  
 .... hrs. .... min.

9. Birthplace Cleveland Cuyahoga Ohio  
 (Town, county, and state)

10. Usual occupation Retired Plate Printer for gov't

## 11. Industry or business

FATHER 12. Name Daniel Wagner  
 13. Birthplace Germany

MOTHER 14. Maiden name Louise Becker  
 15. Birthplace Germany

16. Informant Mrs. Clara S. Wagner  
 Address 118 Carroll Ave., Takoma Park, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof April 13, 1948  
 (month) (day) (year)  
 Cemetery or crematory Cedar Hill Cemetery  
 Location Arthur J. Baller

18. Funeral director Arthur J. Baller  
 Address 254 Carroll St. Takoma Park, D.C.

19. (Date rec'd by registrar) Apr 10 1948 Registrar Arthur J. Baller

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9-48 1948, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1944 to April 9 1948  
 and that I last saw him alive on April 9 1948

Immediate cause of death

Malignant Melanoma  
Generalized

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Howard I. House  
28 Carroll Ave Takoma Park Md  
 Address Date signed 4/9/48

M. D. or other

Date signed



RECEIVED

APR 13 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Va. County \_\_\_\_\_  
 City or town Arlington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1026 So. Queen St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI ✓

## 3. (a) FULL NAME

WASHINGTON, James Edward

## 3. (b) Social Security Number

4. Sex male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced married  
 8. (b) Name of husband or wife Irene Washington  
 7. Birth date of deceased (mo., day, yr.) 18 September 1882  
 8. AGE: Years 65 Months 6 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace Pa.  
 (Town, county, and state)  
 10. Usual occupation unemployed  
 11. Industry or business \_\_\_\_\_

12. Name WASHINGTON, James dec. dec.  
 13. Birthplace N.C.  
 14. Maiden name GIBSON, Matilda dec. dec.  
 15. Birthplace Wash., D.C.

16. Informant wife: Mrs. Irene Washington  
 Address 1026 So. Queen St., Arl., Va.  
 17. burial Date thereof 4-10-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Odd Fellow Cemetery  
Arlington, Va.  
 Location \_\_\_\_\_

18. Funeral director Chinn Funeral Home  
 Address 2605 S. Seminary Rd, Arlington, Virginia

18. 4-7- 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 April 19 48 at 11:35 A.M.

21. I CERTIFY that death occurred on the date above related; that I attended deceased from 19 March 19 48 to 6 April 19 48  
 and that I last saw him alive on 6 April 19 48

Immediate cause of death Suppuration, urine  
due to nephritis, acute DURATION one month

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hypertension clinical  
marked 210/125 September 1947  
 (Include pregnancy within 3 months of death) Shap. Viridans  
Viridans

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE F. E. WETZEL Lt MC USN

M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 4-7-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 10 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 815 Maryland Avenue, N.E., Apt. 207  
(If rural, give LOCATION)  
2.(a) If veteran, name war WWI ✓

### 3. (a) FULL NAME

Charles Stuart WELLS

### 3. (b) Social Security Number

4. Sex male 5. Cntr or race W-US 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Tillie Wells

7. Birth date of deceased (mo., day, yr.) March 15, 1890 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 58 Months 1 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Tenn.  
(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business Gas Co., Wash., D.C.

12. Name WELLS, Preston dec.

13. Birthplace Va.

14. Maiden name TAYLOR, Martha dec.

15. Birthplace Va.

16. Informant wife: Mrs. Tillie Wells

Address 815 Maryland Avenue, Apt. 207, Wash., D.C.

17. burial Date thereof 4-21-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Virginia

18. Funeral director J. William Lee's Sons & Behan

Address 4th & Mass., Ave., Wash., D.C.

19. 4-18 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 18 April 19 48 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 April 19 48 to 18 April 19 48 and that I last saw him alive on 18 April 19 48

Immediate cause of death Thrombosis, Coronary artery DURATION 10 hours

Due to Pneumonia, bronchitis 14 days

Due to Diabetes mellitus 30 yrs.

Other conditions Coronary heart disease, Arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none performed  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury was injured injured at work? \_\_\_\_\_

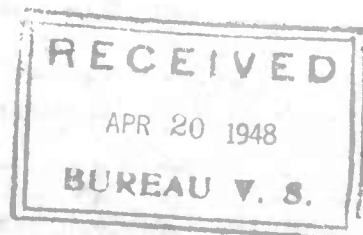
23. SIGNATURE W. A. DINSMORE, Jr. LCDR MC USN  
M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 4-18-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

87c

04069

223

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Montgomery County  
 City or town Takoma Park, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 years 10 mo  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
 How long in hospital or institution? same

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State District of Columbia  
 City or town Washington, D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2023 Park Road, NW  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Thomas C. Willis

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mrs. Catherine M. Willis  
 6. (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) 8/26/1881  
 8. AGE: Years 67 Months 7 Days 22 If less than one day ..... hrs. .... min.  
 9. Birthplace Strasburg, Virginia  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business Banker  
 12. Name James Willis  
 13. Birthplace Floyd Co., Va.  
 14. Maiden name Jake Miller  
 15. Birthplace Strasburg, Va.

16. Informant Removal Date thereof April 12, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Woods & Sons  
 Location 17516 Penna. Ave  
 18. Funeral director Joseph H. Henders  
 Address 4/12/48  
 19. (Date rec'd by registrar) 4/12/48 Registrar John D. ...

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1948 5:00 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 to April 12 1948  
 and that I last saw him alive on April 11 1948  
 Immediate cause of death Transition DURATION terminal  
Parkinson's syndrome 10 yrs.  
 Due to .....  
 Due to .....  
 Other conditions .....  
 (Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....  
 Autopsy results X  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Robert A. Hare M.D. M.D. or other  
Takoma Park, Md. Date signed 4/12/48

**RECEIVED**

**APR 13 1948**

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04070

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Woodmoor, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
10,603 Lorain Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Woodmoor  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 10,603 Lorain Ave.  
 (If rural, give LOCATION)

No. No.  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Otis Alton Worthington

## 3. (b) Social Security Number

52-0544094

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Naomi M.

7. Birth date of deceased (mo., day, yr.) June 18, 1904 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years <u>43</u>	Months <u>9</u>	Days <u>20</u>	If less than one day _____ hrs. _____ min.
----------------------------	--------------------	-------------------	---

9. Birthplace Elloak, Howard, Maryland  
 (Town, county, and state)

10. Usual occupation Real Estate Broker

## 11. Industry or business

FATHER 12. Name John Thomas Worthington

13. Birthplace Cooksville, Md.

MOTHER 14. Maiden name Ida Melissa Groomes

15. Birthplace Unity, Md.

16. Informant Naomi M. Worthington

Address Woodmoor, Md.

17. Burial Date thereof April 10, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Johns Church

Location Olney, Maryland

18. Funeral director Charles E. Pumphrey

Address 8434 Georgia ave., Silver Spring, Md.

19. Apr. 9 19 48 Josephine Schaeff  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 19 48 at 5:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1947 to 8 April 19 48  
 and that I last saw him live on 1/8 month 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

1-2 hours

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hypertensionmitral stenosis

(Include pregnancy within 8 months of death)

5-10 pm15-20 pm

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William D. Leach M.D. M. D. or other

Address Silver Spring, Md. Date signed 8 April 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



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BUREAU V. S.